

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 1 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLEMENIA ABRAHAM		2a. DATE OF DEATH MONTH DAY YEAR 12 26 84		2b. HOUR 7:05 A.M.	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 7 23 26		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY BALT	13c. CITY OR TOWN BALT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST G.W.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE COLVIN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
16b. SOCIAL SECURITY NO. 240-34-1758		17. INFORMANT chart		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp. failure DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral hemorrhage/sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic lung CA to brain PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-14 19 84 , to 12-26 19 84 , that (I) (we) last saw the deceased alive on 12-26 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Steven J. Garon MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 26 Dec 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN GARON		22e. ADDRESS Sinai Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12-29-84	23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM PARK		23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS MD	
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS		ADDRESS 1721-27 N. MONROE STREET		25a. DATE REC'D. BY REGISTRAR DEC 27 1984	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



11/11/11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 1 1

1. DECEASED NAME (TYPE OR PRINT)		FIRST MINNA		MIDDLE K.	LAST ABRAMS		2a. DATE OF DEATH MONTH DAY YEAR DEC. 9, 1984		2b. HOUR 7:45 A.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7. 19 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 74 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6310 GREENSPRING AVE. APT. 205				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE APT. 205 6310 GREENSPRING AVE. 21209			
14. FATHER'S NAME FIRST MIDDLE LAST SIMON KESSLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-42-8773		17. INFORMANT DR. SAMUEL J. ABRAMS 7505 PARK HTS. AVE. BALTO., MD 21208							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Pneumonia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>12/8</u> , 19 <u>84</u> , to <u>DEC 9</u> , 19 <u>84</u> , that (2) I saw the deceased alive on <u>12/8</u> , 19 <u>84</u> , and that in (my) <u>apinion</u> death occurred on the date and hour and from the causes stated above. (1) (my) (did) (did not) view the body after death.											
22b. SIGNATURE <u>B.R. Shochet</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-9-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD R. SHOCHET, MD				22e. ADDRESS 6804 PARK HEIGHTS AVE 21215							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 10, 1984		23c. NAME OF CEMETERY OR CREMATORY BETH HAMEDROSH HAGODOL		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.				25a. DATE REC'D. BY REGISTRAR DEC 12 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					
6010 REISTERSTOWN RD. BALTO., MD 21215											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1, and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 4 1 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Grace Adams</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>12 15 84</i>		2b. HOUR <i>4:40 AM</i>	
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 09 12</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>72</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secours Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Western Electric</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>BALTO</i> 13c. CITY OR TOWN <i>BALTO</i> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <i>603 N. Payson 21217</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ed Coker</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNIE DORA</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-09-7467</i>		17. INFORMANT ADDRESS <i>Mr. Roy Adams 603 N. Payson St.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>congestive heart failure, ventricular arrhythmias</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/13</i> 19 <i>84</i> to <i>12/15</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>12/15</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>James Evans MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/15/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James Evans MD</i>		22e. ADDRESS <i>700 Washington Blvd, Baltimore, Md 21201</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-20-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Garrison Forest</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Garrison Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>JAS. A. MORTON & SONS 1701 LAURENS</i>			
25a. DATE REC'D. BY REGISTRAR <i>DEC 20 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Gulia Davidson-Randers</i>			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 1 3

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Zebedee Adams</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Dec. 1-84</i>		2b. HOUR <i>P.M.</i>
3. SEX <i>male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 8-12</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>201 N. Washington St. Apt. 1107</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Tailor</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i>			13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Adams</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sallie Torence</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>238-206471</i>		17. INFORMANT ADDRESS <i>Lillian Holloway 201 N. Washington St. Apt. 1107</i>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>squamous cell carcinoma of the Pancreas</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>chronic obstructive pulmonary disease</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> 19 <i>84</i> , to <i>Dec 1</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>Nov 30</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Patricia A Tewes</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>12-3-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Patricia A Tewes</i>		22e. ADDRESS <i>Johns Hopkins Hospital 600 N Broadway Baltimore MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>12-5-84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cmt.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore MD.</i>	
24. FUNERAL DIRECTOR NAME <i>Randolph J. Tedlick</i>		ADDRESS <i>2431 E. Oliver St.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 3 1984</i>	25b. REGISTRAR'S SIGNATURE <i>Wanda Davidson-Randall</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 2 4 1 4			
1. DECEASED NAME (TYPE OR PRINT) ANTHONY AGRO SR.										2a. DATE OF DEATH MONTH DAY YEAR 12/27/84		2b. HOUR MIN. 8:28 P	
3. SEX M		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 28 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS 73		IF UNDER 24 HRS. HOURS MIN. 73			
7a. BIRTHPLACE TEXOKO, PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD							
10. CITY OR TOWN OF DEATH BALTO MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UTILITY AID		12b. KIND OF BUSINESS OR INDUSTRY CIVIC CENTER BALTO					
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3023 PENNA. AVE. 21227					
14. FATHER'S NAME FIRST MIDDLE LAST JOHN AGRO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AIFONSINA CACCIATORE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (UNKNOWN) (IF YES, GIVE WAR OR DATES) YES. 1927-1931		16b. SOCIAL SECURITY NO. 213096706		17. INFORMANT AUDREY J. AGRO				ADDRESS SAME AS 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 12/26 19 84 , to 12/27 19 84 , that (I) (we) last saw the deceased alive on 12/27 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE Joseph Bonelli						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Bonelli						22e. ADDRESS St. Agnes Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/31/84		23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Ceme. Crownsville A.A.C.		23d. LOCATION CITY OR TOWN COUNTY STATE CROWNVILLE A.A.C. MD.						
24. FUNERAL DIRECTOR NAME McCully Funeral Home						ADDRESS 2376 Patuxent Ave BALTO, MD 21225		25a. DATE REC'D. BY REGISTRAR DEC 31 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

1

Handwritten text, mostly illegible due to fading and bleed-through. Visible fragments include:

- Top right: "117110"
- Top center: "JAN 20 1950"
- Top left: "12"
- Left margin: "RECEIVED"
- Center: "JAN 20 1950"
- Bottom left: "12"
- Bottom center: "JAN 20 1950"

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 4 1 5
REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7c. DATE PRONOUNCED DEAD		7d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE ESTIMATED		Male		White		8-29-84		63 YRS.		12-9 19 84		12:55 P. M.	
2. William F. Ahlers		XX 12-8 19 84													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
New York		U.S.A.				Baltimore City, MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		834 Washington Boulevard		Stock Clerk											
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS									
Md.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		834 Washington Blvd.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
William Ahlers		Catherine Mullan		Yes		W.W. II 116-09-2637		Robert T. Ahlers							
								ADDRESS 166 W. 87 St. 10024 Manhattan N.Y.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
PART I DEATH WAS CAUSED BY:						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
IMMEDIATE CAUSE (a) Ethanolism															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		HOUR A.M. MONTH DAY YEAR													
		P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION											
				STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED											
Dennis F. Smyth		M.D. Assistant		12-10-84											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
Dennis F. Smyth, M.D.		111 Penn St., Balto., Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION									
Burial		12/13/84		Crownsville Md. VA		CITY OR TOWN		COUNTY		STATE					
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Lilly & Zeiler Inc.		1901 Eastern Ave.		21231		14 1984									

20. FOLLOW-UP

CHIEF OF POLICE

NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or initialed, it shows any injury, or other traumatic event; the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 4 1 6			
1. DECEASED NAME (TYPE OR PRINT) Yahya Albeishi				2a. DATE OF DEATH MONTH DAY YEAR December 15, 1984		2b. HOUR 8:25P M	
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1952		6. AGE (IN YEARS LAST BIRTHDAY) 32	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Saudia Arabia		7b. CITIZEN OF WHAT COUNTRY? Saudia Arabia		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saudia Arabia		12b. KIND OF BUSINESS OR INDUSTRY Air Force	
13a. STATE Saudia Arabia		13c. CITY OR TOWN Jedha		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE King Fahd Arm Forces Hospital 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Eisa Albeishi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Sulaiman Al-Bassam Arlington, Va. U.S.A. Embassy Of Saudi Arabia					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hyperkalemia DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Chronic Renal Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 15, 1984 to December 15, 1984 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 15, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mohammad Aslam				DEGREE M.D.		22c. DATE SIGNED 12/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOHAMMAD ASLAM				22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-22-84		23c. NAME OF CEMETERY OR CREMATORY Jedha Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Jedha Saudia Arabia	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE Lidia Davidson-Randall	

1941

Jan. 1, 1941

Washington, D.C.

Mr. J. Edgar Hoover

Sir:

Enclosed for you are

three

copies of a

report

dated

Jan.

Washington, D.C. 20535
Bureau of Investigation, U.S. Department of Justice

Very

Respectfully,

Very truly yours,

x

Enclosure

100-100000

100

100-100000



U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

100-100000

100-100000

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted and a check marked.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 4 1 7			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST MARY ALDER				2b. DATE OF DEATH MONTH DAY YEAR DECEMBER 14, 1984			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 13, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MIDDLE COUNTY				13b. CITY OR TOWN PIKESVILLE			
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS / ZIP CODE 1 SLADE AVE., APT. 703 #21208			
14. FATHER'S NAME FIRST MIDDLE LAST EMANUEL GURWITZ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETTA UNKLEIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 219-10-3803			
17. INFORMANT ADDRESS MRS. PHYLLIS ZHEUTLIN 21117 32 CAVESWOOD LA, OWINGS MILLS, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINUTE 30 MINUTE 15 YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 12-9, 1984, to 12-14, 1984, that (1) (we) last saw the deceased alive on 12-14, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.							
22b. SIGNATURE M C Beyunes				DEGREE M D		22c. DATE SIGNED 12-14-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK Beyunes				22e. ADDRESS 600 N. WILFORD ST JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-16-84		23c. NAME OF CEMETERY OR CREMATORY HAR SINAI CONG.		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS BALTO. MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 19 1984			

RECEIVED

1911



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="display: flex; justify-content: space-between;"> <div> FOR STATE REGISTRAR </div> <div> 3 2 4 1 8 REG. NO </div> </div>									
1. DECEASED NAME (TYPE OR PRINT) <i>Joseph B Alexander</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>12 29 84</i>		2b. HOUR <i>1:55 AM</i>	
3. SEX <i>M</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>04 14 39</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>45</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S. Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Johns Hopkins</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Truck Driver</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Superior Fuel Company</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>MD</i>		13b. COUNTY <i>BAL</i>		13c. CITY OR TOWN <i>BAL</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1159 N. Stricker St. 21217</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Granville Simms</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mattie Alexander</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>249-60-8585</i>		17. INFORMANT <i>Mattie Simms</i>					
3329 <i>ADDRESS</i> <i>Mondawmin Avenue</i> <i>Baltimore, Maryland 21216</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION <i>12/29/84</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Metastatic Cancer Inability to Eat</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>22 S. Francis St Baltimore, Maryland</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 7</i> , 19 <i>84</i> , to <i>Dec 29</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>Dec 29</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>David L. Goodman</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12/29/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Goodman</i>						22e. ADDRESS <i>22 S. Francis St</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/2/1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Memorial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Nutter & Sons 2501 Gwynns Falls Parkway Funeral Home Inc. Baltimore, Maryland 21216</i>						25a. DATE REC'D. BY REGISTRAR <i>JAN 7 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

BP

TABLE 1. (continued)

10

2007/11/28 14:00:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32419			
1. FOR - STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANGELA Marie ALLEN			
2a. DATE OF DEATH MONTH DAY YEAR 11 28 84		2b. HOUR 3:34 PM		3 SEX Female		4 RACE White	
5. DATE OF BIRTH MONTH DAY YEAR 10 4 77		6. AGE (IN YEARS (LAST BIRTHDAY)) 7 YRS		7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD		10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MT. WASHINGTON Peds Hosp.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dependent		12b. KIND OF BUSINESS OR INDUSTRY ---		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY PG		13c. CITY OR TOWN SUITLAND	
14. FATHER'S NAME FIRST MIDDLE LAST David Lee Richardson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carol Sue Allen		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No --		16b. SOCIAL SECURITY NO. 578-82-8408	
17. INFORMANT ADDRESS 5631 Regency Pk Ct Suitland, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) VENTILATOR DEPENDENT SECONDARY TO DUE TO, OR AS A CONSEQUENCE OF (c) NEAR MISS SIDS.		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 4:25, 19 84, to 11:28, 19 84, that (I) (we) last saw the deceased alive on 11-28, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Irene DUNG M.D.	
22c. DATE SIGNED 11-28-84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRENE DUNG M.D.		22e. ADDRESS M.W.P.H.		22f. DATE REC'D. BY REGISTRAR DEC 05 1984	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-4-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home		24b. ADDRESS Suitland, Md.		24c. REGISTRAR'S SIGNATURE J. L. Linder		24d. REGISTRAR'S NAME J. L. Linder	



[Faint, illegible handwritten text at the bottom left corner.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

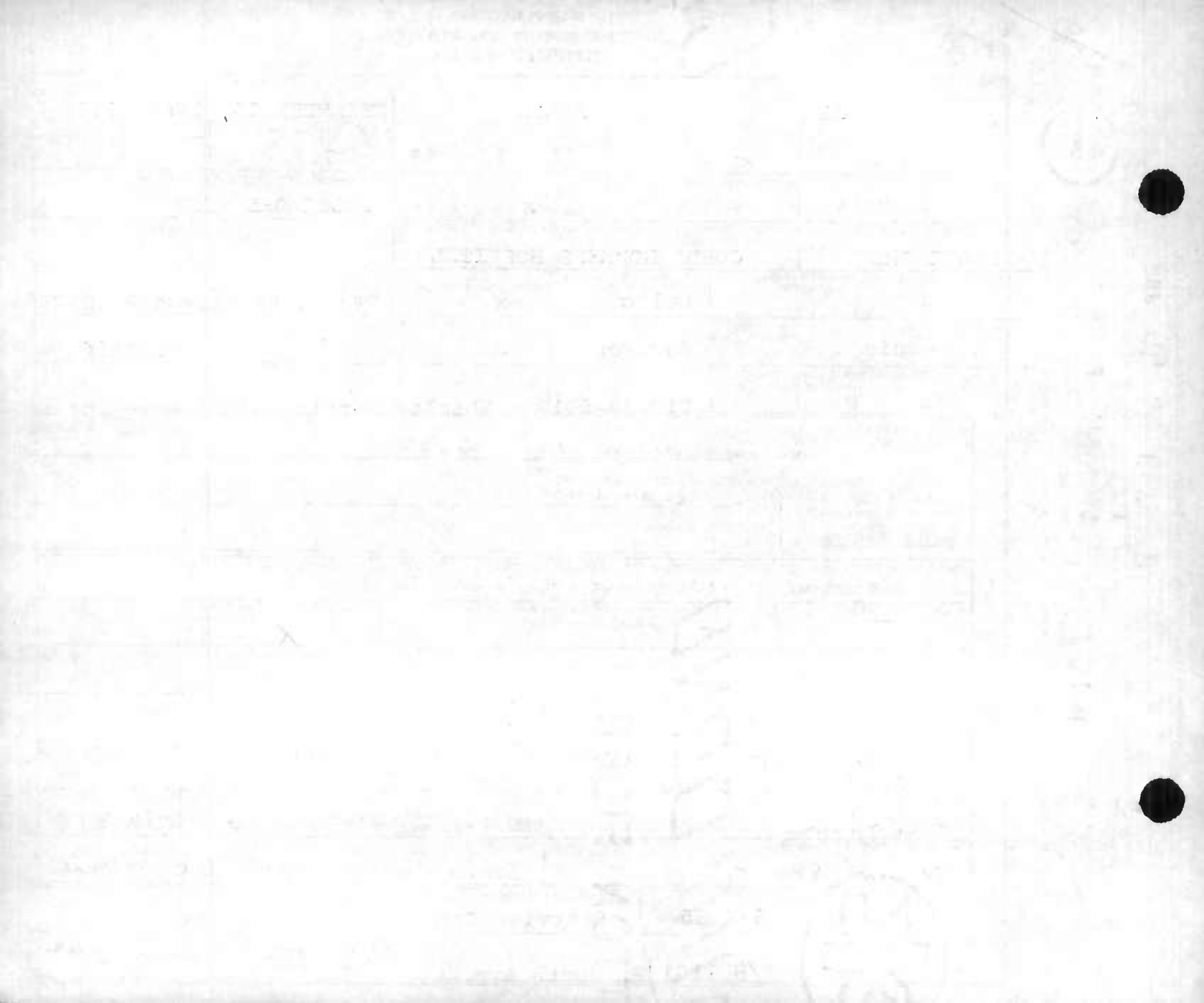
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		3 2 4 2 0		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) MAY ALLEN				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 30, 1984		2b. HOUR 3:35 P M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 13 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 943 N. Patterson Pk. 21205			
14. FATHER'S NAME FIRST MIDDLE LAST Gennie Jackson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Macruff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-34-6016		17. INFORMANT ADDRESS Shirley Morrison 1717 Nome St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>asphyxiation</u> (c) <u>due to, or as a consequence of</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>metastatic stomach cancer with liver mets</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>84</u> , to <u>12/30</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Maura McGuire</u>				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maura McGuire				22e. ADDRESS Johns Hopkins Hospital Dept Medicine					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-4-85		23c. NAME OF CEMETERY OR CREMATORY Eastview Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. City			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D BY REGISTRAR JAN 3 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32421			
1- FOR STATE REGISTRAR							
1 DECEASED NAME FIRST MIDDLE LAST RUTH Bolton Allen				2a DATE OF DEATH MONTH DAY YEAR DEC. 15, 1984		2b HOUR 4:45A M	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 4 5 1905		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a STATE Md.		13b COUNTY		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Jole Bolton				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearlie Mitchell			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-20-0066		17 INFORMANT ADDRESS Willie Mae Kelly 1615 Northgate Rd. 21218			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>IDIOPATHIC CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo 10 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF INJURY, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>11/17/84</u> , 19 <u>84</u> , to <u>12/15</u> , 19 <u>84</u> , that I have last saw the deceased alive on <u>12/15</u> , 19 <u>84</u> (and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE M. Earl Heard III				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/15/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) M. EARL HEARD III				22e ADDRESS JOHNS HOPKINS HOSPITAL			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/18/84		23c NAME OF CEMETERY OR CREMATORY Crownsville		23d LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md.	
24 FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE DEC 17 1984 Julia Davidson-Rendell			

100%

100%

100%

100%



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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MEDICAL CERTIFICATION

2
9

1

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 4 2 2 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA J. ALSTON				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 23, 1984				2b. HOUR P M 4:23 P M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 13 23		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1924 Lauretta Ave. 21223	
14. FATHER'S NAME FIRST MIDDLE LAST Thornton Jackson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Banks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-28-7036		17. INFORMANT ADDRESS Mary Crippens 1521 N. Wolfe St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastric hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>gastric stress ulcers</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe asthmatic attack</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 days</u> <u>3 weeks</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>									
19a. DATE OF OPERATION <u>none</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>December 1, 1984</u> to <u>December 23, 1984</u> , that (I) (we) lost saw the deceased alive on <u>December 23, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph M Molina MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>12/23/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph M Molina MD</u>				22e. ADDRESS <u>Johns Hopkins Hospital Baltimore MD 21205</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-28-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Wm. C. March F/H 101 E. North Ave.</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 27 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

468 VA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 2 3
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT Lee ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR 12 23 84		2b. HOUR DAY MIN. 2 A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 07 10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brunswick, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trainman		12b. KIND OF BUSINESS OR INDUSTRY Railroad
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Washington Brunswick			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8 West C St 21716
14. FATHER'S NAME FIRST MIDDLE LAST Richard Lee Anderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Virginia Grove			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-03-2884		17. INFORMANT ADDRESS MRS. June Deener - Daughter	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Multiple organ failure**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Infected graft**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 10/8/84	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Infected Graft	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/4 19 84 , to 12/23 19 84 , that (I) (we) last saw the deceased alive on 12/23 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death.			
22b. SIGNATURE Aysel K. Sanderson, MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12/23/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aysel K. Sanderson, MD		22e. ADDRESS Univ. Hosp. 22 S. Greene St.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/26/84	23c. NAME OF CEMETERY OR CREMATORY Park Heights Cent. Brunswick, Fred. Md.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME John T. Williams Funeral		ADDRESS 100 Petersville Road, Brantford, Pa.	25a. DATE REC'D. BY REGISTRAR JAN 3 1985
		25b. REGISTRAR'S SIGNATURE Julian [Signature]	

BRASSER, Mrs. W. S. H.

Trinidad Railways

Richard Lee Anderson Thomas Virginia Green
Mrs. Jane Green - Daughter

John William Thomas
Bar 101 12/20/2012 (not brasserie, Fred. No.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

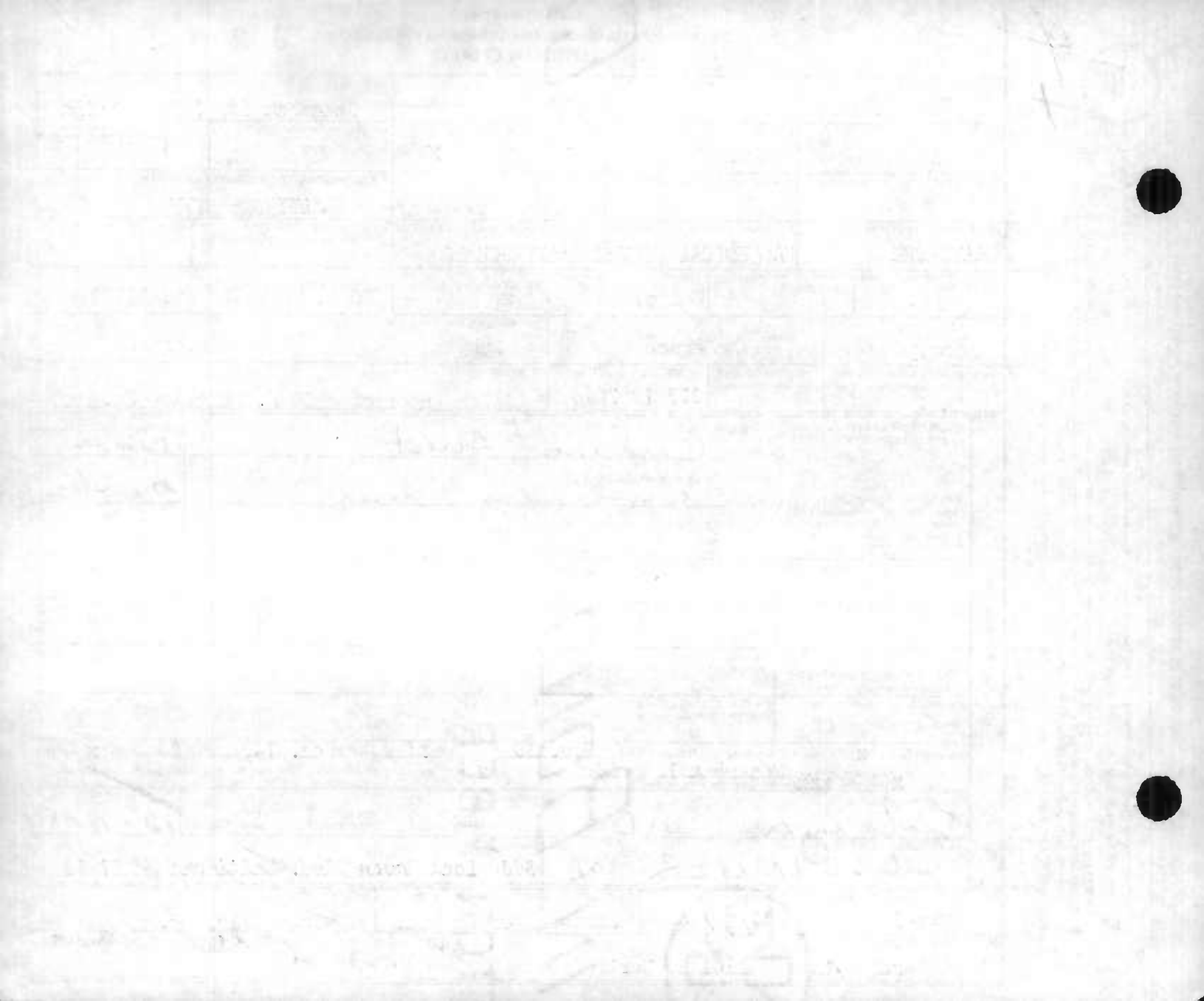
REG. NO.

3 2 4 2 4

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN E. ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR December 18, 1984		2b. HOUR 7:25a M.		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 16 17		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTIMORE MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 50 N. Bentalou St. 21223	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Anderson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby Anderson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 173 10 7884		17. INFORMANT ADDRESS Odelia Anderson 50 N. Bentalou St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Terminal Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 30 , 19 84 , to Dec. 18 , 19 84 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 18 , 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE BOLLINGER MD				DEGREE MD		22c. DATE SIGNED 12-18-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BOLLINGER MD				22e. ADDRESS 3900 Loch Raven Blvd. Baltimore Md 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet.		23d. LOCATION CITY OR TOWN COUNTY STATE Owing Mills, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 19 1984	
				25b. REGISTRAR'S SIGNATURE John D. ...			

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 2 5

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Katherine Nancy Andrae			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1984		2b. HOUR 3:00 a.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 9, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4110 Curtis Avenue, 21226		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic
13a. STATE Maryland		13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John --- Sitar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine --- Kirbely			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-10-6780		17. INFORMANT ADDRESS Albert H. Andrae Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastasis to Brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>metastasis to Brain</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> Office		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> 19 <u>84</u> , to <u>Dec 18</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Dec 9</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Colvin C. Carter M.D.				22c. DATE SIGNED 12/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Colvin C. Carter M.D.				22e. ADDRESS 4700 Pennington Ave., Balto., Md. 21226	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY A. A. Co.		23f. STATE Md.	
24. FUNERAL DIRECTOR NAME McCurly Funeral Homes				25a. DATE REC'D. BY REGISTRAR DEC 19 1984	
25b. REGISTRAR'S SIGNATURE John S. ...					

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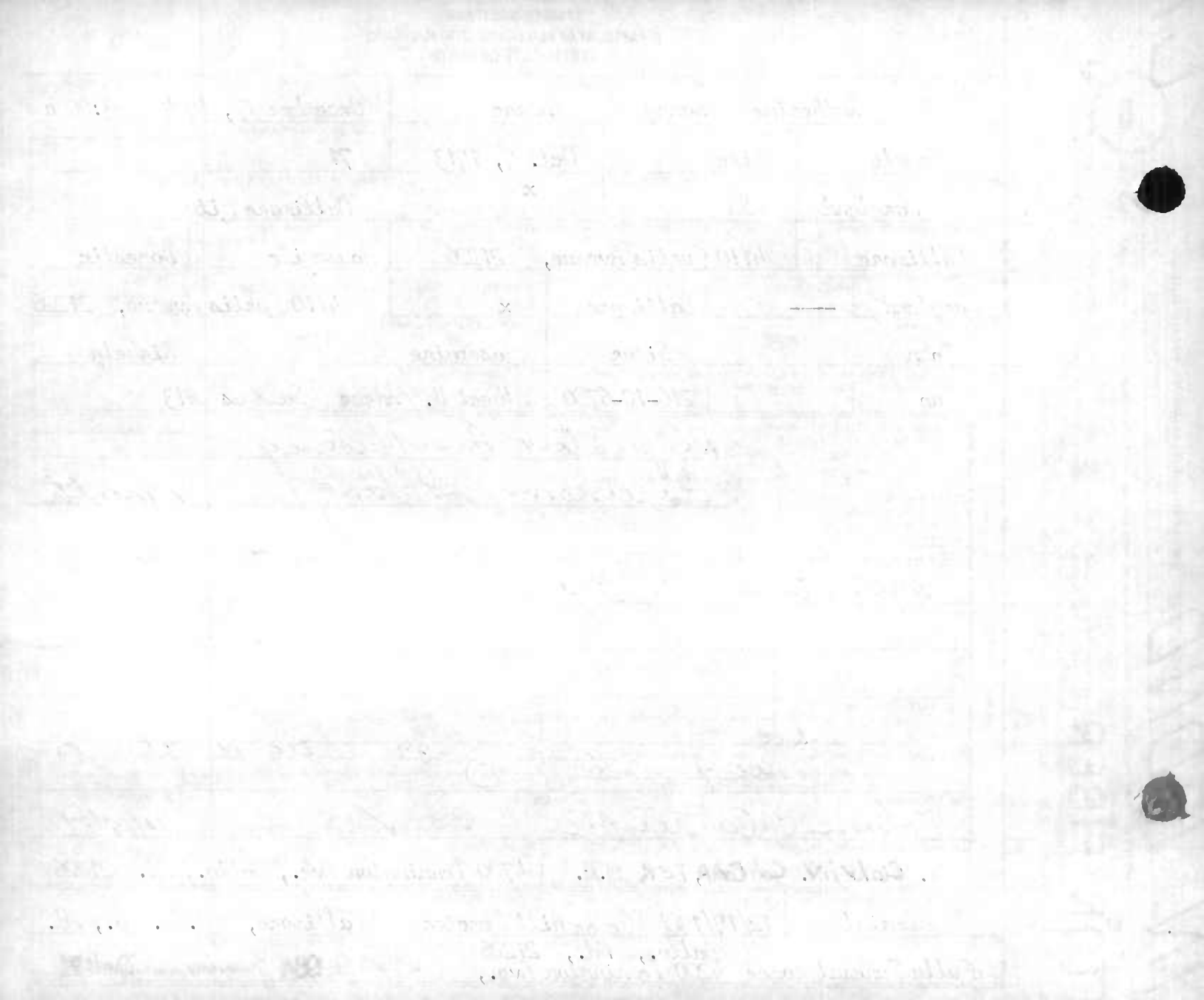
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 4 2 6			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR 12 26 84			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Olive T. Archer				2b. HOUR 6 25 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 18, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAGEWOOD Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT Home		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND 13c. COUNTY BALTIMORE 13d. CITY OR TOWN Parkville				13e. STREET ADDRESS / ZIP CODE 8418 Nunley Drive 21234			
14. FATHER'S NAME FIRST MIDDLE LAST OVERTON C. TABLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Snyder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220 46 5224		17. INFORMANT ADDRESS FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerosis Cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Malnutrition							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from April 19 84, to Dec 26 19 84, that (2) (we) lost saw the deceased alive on Dec 22 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Christine Hernandez MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christine Hernandez MD				22e. ADDRESS 11722 Reisterstown Rd Reisterstown, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Dec. 31, 1984		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS Evans Chapel of Memories HARFORD ROAD 8800				25a. DATE REC'D. BY REGISTRAR DEC 31 1984 25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

1

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32427					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PATRICIA L. Argo				2a. DATE OF DEATH MONTH DAY YEAR 12-25-84				2b. HOUR 7:44^{PM}	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1935		6. AGE (IN YEARS (LAST BIRTHDAY)) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Cntr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Mfg.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 140 S. East Avenue 21224			
13a. STATE Md.		13b. COUNTY ---		13c. CITY OR TOWN Baltimore					
14. FATHER'S NAME FIRST MIDDLE LAST Armand --- Aiaché		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen R. Baranowski							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-30-9700		17. INFORMANT Baltimore, Md. 21224 Mrs. Helen R. Aiaché-140 S. East Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripartum anoxia DUE TO, OR AS A CONSEQUENCE OF (b) Chelastotic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 1 MONTH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11 , 19 84 , to 12/25 , 19 84 , that (I) (we) lost saw the deceased alive on 12/21 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.									
22b. SIGNATURE G. Purcell				DEGREE				22c. DATE SIGNED 12/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL PURCELL				22e. ADDRESS 15 KNC 4940 EASTMAN AVE BALT MD 21214					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME John A. Moran, Inc. Funeral Home				DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall			
3000 E. Baltimore St., Balto., Md. 21224									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of choice.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 2 8

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KENNETH L. ARMIGER			2a. DATE OF DEATH MONTH DAY YEAR 12 10 84		2b. HOUR 11:20 ^{AM}		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 16, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELEC. TECH.		12b. KIND OF BUSINESS OR INDUSTRY SALARIED	
13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1141 GLORIA AVE. 21227	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ARMIGER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN FROME			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. KOREA 220-24-1364		17. INFORMANT ADDRESS Mrs. Dolores Armiger 1141 Gloria Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MARKED GENERALIZED ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James E. Taylor				DEGREE M.D.		22c. DATE SIGNED 12/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MACHIRAN JAMES E. TAYLOR				22e. ADDRESS ST. AGNES HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/13/84		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Garrison Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Ambrose, Inc. 1328 Sulphur Spring Rd.				25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 11 1984			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 2 4 2 9

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR					
Donald						Arnette		12/7/		19		84				M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		24 HOUR	
M		Cauc		May 8, 1935		49 YRS.						12/ 7/		1984		A		M		11:10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
Virginia		U.S.A.				Baltimore City,															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		Johns Hopkins Hospital																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		118 S. Patterson Pk. Ave.													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
Wentz		Harris		Yes		Inez Childress		PART I DEATH WAS CAUSED BY:													
				Unknown		2304 E. 9th St.		IMMEDIATE CAUSE (a) _____													
								Gunsight Wound to Head													
								DUE TO, OR AS A CONSEQUENCE OF													
								(b) _____													
								DUE TO, OR AS A CONSEQUENCE OF													
								(c) _____													
								PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
		11:00 PM 12/6/84		subject shot during argument																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																	
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		house		118 S. Patterson Park Ave., Balto. City, Md.																	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED																	
Gregory R. Kauffman, M.D.		M.D. Assistant		12/7/84																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
Gregory R. Kauffman, M.D.		111 Penn St.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		23e. COUNTY		23f. STATE											
Burial		12.13.84		Powell Valley Cem		Dryden		Lee Co.		Va.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR SIGNATURE															
Raymond L. Kaczorowski		2525 Fleet St.		DEC 11 1984		John Davidson															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))

20% ON FILE

REVENUE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 3 2 4 3 0

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Paul D. Arnold								XX		12-31		19		84		M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
Male	White	10 22 32		52 YRS.						12-31		19		84		8:24 p.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.		WIDOWED		DIVORCED		Baltimore City,											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		South Baltimore General Hospital		Chauffeur		Cab Co.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Baltimore		Baltimore		YES NO		601 Freeman Street 21225											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Benjamin		Mary																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		Korean		212-30-2498		Phillip D. Arnold		Same as 13e											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
8147 IMMEDIATE CAUSE (a) Multiple Injuries																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES XX NO							
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
6:58 P.M. 12-31 1984				pedestrian struck by auto															
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
XX				road				Church & 6th Sts., Glen Burnie, Anne Arundel Co., Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from Natural causes, Accident XX, Suicide, Homicide, Undetermined manner.																			
22b. TITLE (SPECIFY)																			
M.D. Assistant MEDICAL EXAMINER																			
DATE SIGNED 1-1-85																			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Dennis F. Smyth, M.D.				111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				1/5/85				Cedar Hill Cemetery				Balto A.A. Md							
24. FUNERAL DIRECTOR																			
George J. Gonce 4001 Ritchie Hgwy Balto Md																			
25a. DATE REC'D. BY REGISTRAR																			
JAN 7 1985																			
25b. REGISTRAR'S SIGNATURE																			
a. Davidson-Rendell																			

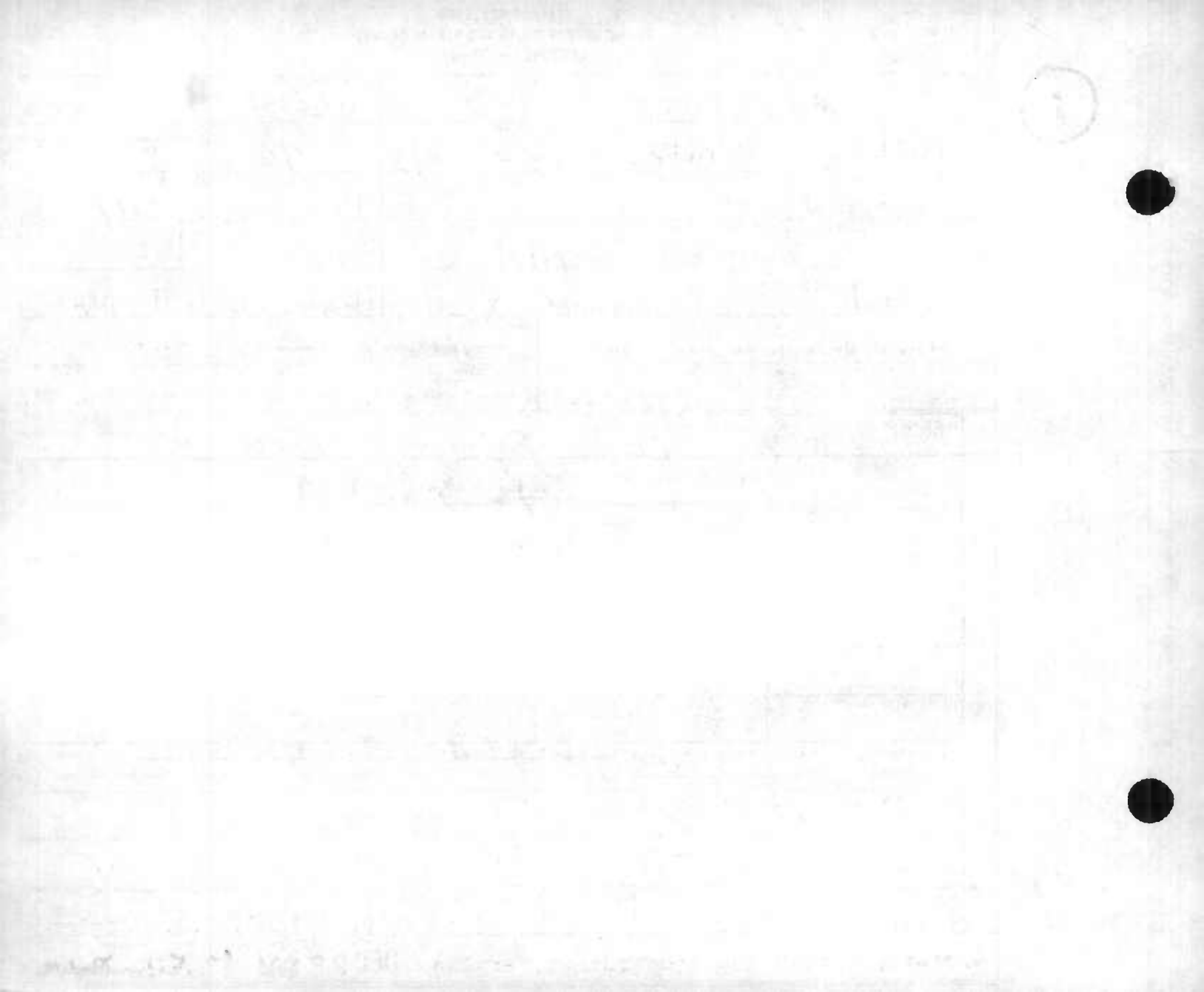
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 3 2 4 3 1							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST EUGENE K ASHBY				2a. DATE OF DEATH MONTH DAY YEAR 12/25/84		2b. HOUR 5:00 PM	
3 SEX MALE		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-26-13		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH Virginia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Federal Hill NH 21230	
14. FATHER'S NAME FIRST MIDDLE LAST XXXXXXX Robert Lee Ashby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST XXXXXXX Emma Baxter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes Army		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT Charlotte M. Ashby		ADDRESS Colton Point, Md.		20626	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Bile Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Urine disorder									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/24/84 19 to 12/25/85 19, that (I) (we) last saw the deceased alive on 12/25/85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE V.K. PARASHER		DEGREE				22c. DATE SIGNED 12/25/84		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.K. PARASHER		22e. ADDRESS Lutheran Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland			
24. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP
DHMH - 16 50M 4/83
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 3 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Ruth</u> MIDDLE <u>M.</u> LAST <u>Atkins</u>					2a. DATE OF DEATH MONTH <u>12</u> DAY <u>9</u> YEAR <u>84</u>			2b. HOUR <u>11⁰⁰</u> <small>AM</small>			
3. SEX <u>Female</u>		4. RACE <u>CAU</u>		5. DATE OF BIRTH MONTH <u>3</u> DAY <u>4</u> YEAR <u>11</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS.		7. IF UNDER 1 YEAR MONTHS <u>—</u> DAYS <u>—</u>		8. IF UNDER 24 HRS. HOURS <u>—</u> MIN. <u>—</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> <small>MD.</small>					
10. CITY OR TOWN OF DEATH <u>Baltimore, Md.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Lutheran Hospital</u>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>—</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> 13b. COUNTY <u>Baltimore</u>						13c. CITY OR TOWN <u>—</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>Spring Grove Hosp 21228</u>	
14. FATHER'S NAME FIRST <u>Unknown</u> MIDDLE <u>—</u> LAST <u>—</u>					15. MOTHER'S MAIDEN NAME FIRST <u>—</u> MIDDLE <u>—</u> LAST <u>Unknown</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>UNKO</u>		16b. SOCIAL SECURITY NO. <u>258-265147</u>		17. INFORMANT ADDRESS <u>Morris Plains N.J.</u> <u>William Atkins 33 Glen Cove Road</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Multiple System Failure</u>											
19a. DATE OF OPERATION <u>11/8/84</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Refracted ulcer</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>—</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED <u>12/10/84</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/8/84</u> , 19 <u>84</u> , to <u>12/9/84</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>12/9/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>John J. Arisueno</u> DEGREE <u>—</u>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ARISUENO J.</u>					22d. ADDRESS <u>730 Ashburton St. Baltimore 21214</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-14-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem Pk</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Elkridge Howard Md.</u>		25. DATE PREP'D BY REGISTRAR 75b. REGISTRAR'S SIGNATURE <u>DEC 14 1984</u>			
24. FUNERAL DIRECTOR NAME <u>MacNabb Funeral Home</u> ADDRESS <u>Catonsville Md</u>											

MEDICAL CERTIFICATION

2
9

1

P



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 3 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) EARL AUBREY										2a. DATE OF DEATH MONTH DAY YEAR 12 1 84			2b. HOUR 5 A.M.	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR JAN. 3 1915			6. AGE (IN YEARS LAST BIRTHDAY) MONTH YRS 69			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10. CITY OR TOWN OF DEATH Balto.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. STATE Md.			13b. COUNTY -			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 501 W. Franklin St. 21201			
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Aubrey						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leña Grace								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no						16b. SOCIAL SECURITY NO. 217-03-6264-AA		17. INFORMANT ADDRESS 3668 Kenyon Ave. Margaret Bailey 21213						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 10/25 19 84 to 12/1 19 84 that (I) (we) last saw the deceased alive on 12/1 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not view the body after death.)														
22b. SIGNATURE [Signature]						DEGREE				22c. DATE SIGNED 12/1/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Conpher						22e. ADDRESS Lutheran Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12-3-84			23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory			23d. LOCATION CITY OR TOWN Balto. COUNTY Md. STATE		23e. DATE REC'D. BY REGISTRAR DEC 4 1984			
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc.						25b. REGISTRAR'S SIGNATURE [Signature]								



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

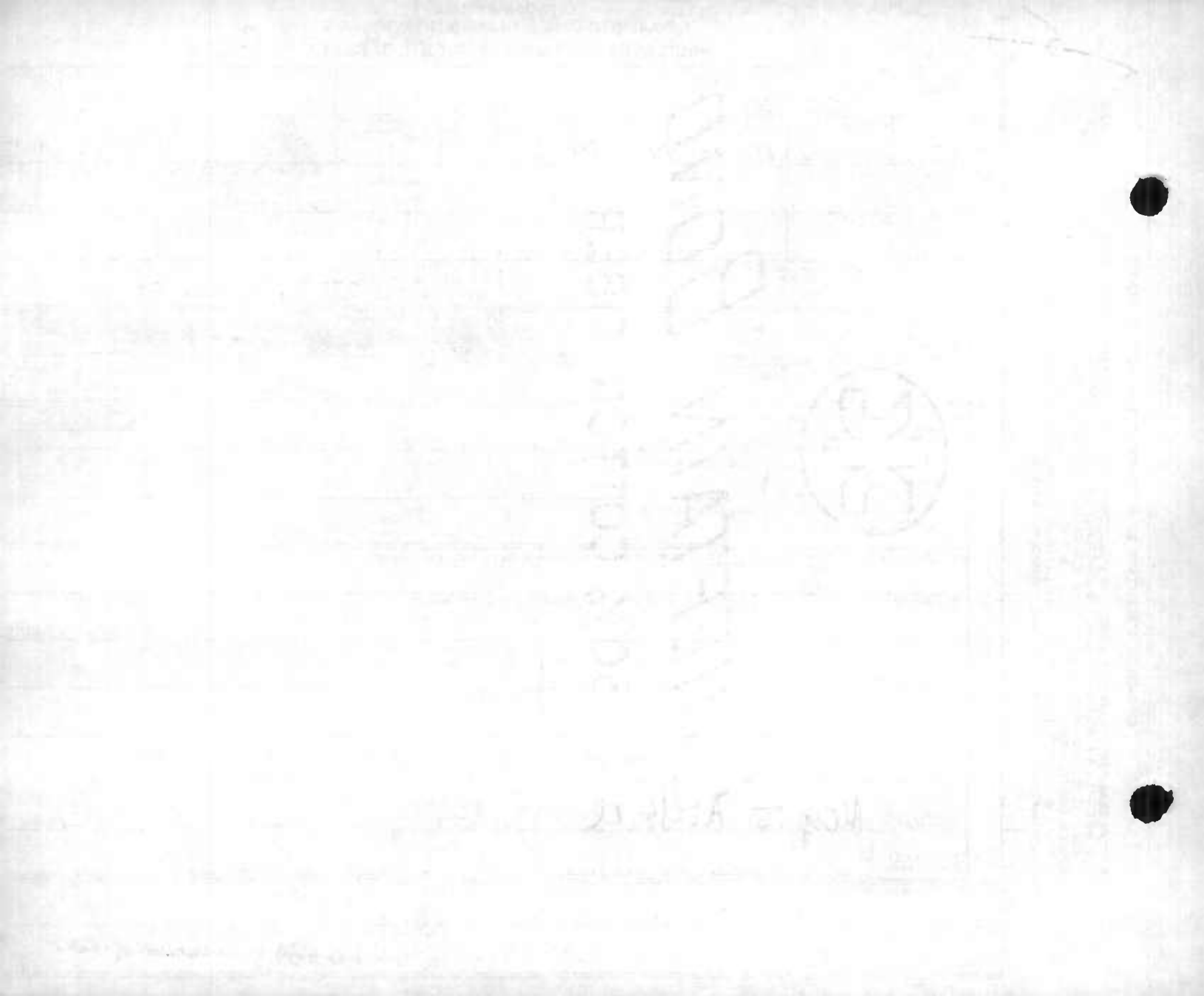
3 2 4 3 4
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		X MONTH DAY YEAR		2b HOUR	
FLORENCE				BAINES				12 12 1984				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d HOUR	
Female	Black	11 28 1900		84 YRS.						12 12 1984		11:48	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		am			
Md		U S A		WIDOWED		DIVORCED		Baltimore				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		Johns Hopkins Hospital											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		Balto.		Balto.		YES X NO		915 N. Durham Street					
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME							
Simon		Bell		Bell		Laura		Bell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No				Lester B. Wallace		4403 Ethland Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES X NO									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
Margarita A. Korell		M.D. Assistant		12/13/84									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Margarita A. Korell, M.D.		111 Penn Street, Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE			
Burial		12/17/84		Eastview Mem. Pk.		Baltimore, Md.							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm C March F/H		1101 E. North Ave.				DEC 18 1984		Julia Davidson-Randall					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 3 5
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		12-10-84 1207 AM	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)	
West Virginia		U.S.		64 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Balto.		Bon Secours Hosp.		Balto. City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Driver		Trucking			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE	
13a. STATE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2201 W. Pratt St. 21223	
13a. Md.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Frank F. Bain		Bessie McLucas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-18-2560		1824 Park Ave. Balto., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe endstage Cardiomyopathy</i>					
(c) <i>possible sepsis.</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) <i>Severe Congestive Heart Failure 2 wks (B)</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10</i> 19 <i>84</i> to <i>12/10</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>12/10</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>Morcesino D. Albuerne</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<i>12/10/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<i>Morcesino D. Albuerne</i>		<i>Bon Secours Hosp.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Removal		12/10/84			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Anatomy Board		Balto., Md.		<i>DEC 13 1984</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 3 6
REG. NO.

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		James F. Bair		12	26	84	3:52 AM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 74 HRS	
Male	White	10 28 1913	71 YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania	U.S.A.		Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Francis Scott Key Med.Center		Operating Engineer-Union				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE		
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	900 N. Kresson Street 21205			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
Raymond Bair		Lola Decker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		WW II		160-14-1267		Forrest T. Bair Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) ASYSTOLE							5 minutes
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION							3 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE							?
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/22, 1984, to 12/26, 1984, that (I) (we) lost saw the deceased alive on 12/26, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
B. F. Hall MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/26/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
B. F. Hall		c/o FRANCIS SCOTTEY MED. CTR.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		12/29/1984		Holly Hill		City or Town County State	
						White Marsh Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222		DEC 31 1984		Lila Davidson-Randall			

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 2 4 3 7

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES R. BAKER		MONTH DAY YEAR DECEMBER 26, 1984		10:50 PM	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7/17/24	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY -		13c. CITY OR TOWN BALTO
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL L. BAKER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA M. SEITZ		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 217 12 3905		17. INFORMANT ADDRESS MARGARITA BAKER ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Metastatic Carcinoma of lung = DUE TO, OR AS A CONSEQUENCE OF Metastasized to brain (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 23, 1984 to December 26, 1984 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 26, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE Rebecca E. Byrd				22c. DATE SIGNED 1984 December 26	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rebecca E. Byrd MD				22e. ADDRESS c/o Maryland General Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/29/84		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.		24. FUNERAL DIRECTOR NAME ADDRESS Connelly Funeral 300 Mace Ave			
25a. DATE REC'D. BY REGISTRAR DEC 28 1984				25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

29

BP 13

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 3 8 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE BAKER					2a. DATE OF DEATH MONTH DAY YEAR 12 06 84			2b. HOUR 9:27 PM				
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 12 10 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF BALTIMORE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND					13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 5715 PARK HEIGHTS AV 21215	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Wilson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 217-22-3343		17. INFORMANT ADDRESS Ethel Watson 201 N. Washington St Apt 910					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (c) MYOCARDIAL INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 2 days												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ADOM, HTN												
19a. DATE OF OPERATION 12/9/84				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (ENTER MOST MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12/3/84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET)		CITY OR TOWN		COUNTY STATE		
22a. I certify that I (this hospital) attended the deceased from 12/6/84 to 12/6/84 , that (I) (we) last saw the deceased on 12/6/84 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If medical examiner view the body after death.)												
22b. SIGNATURE R SEGAL				DEGREE MD				22c. DATE SIGNED 12/6/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R SEGAL				22e. ADDRESS 10 SINAI HOSPITAL BALTIMORE								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/10/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Park			23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md			
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave						25a. DATE REC'D. BY REGISTRAR DEC 11 1984		25b. REGISTRAR'S SIGNATURE Felia Davidson-Rondelle				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 4 3 9

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MIDDLE Florence BAKER			2a. DATE OF DEATH MONTH DAY YEAR 12/22/84			2b. HOUR 12:45 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 13 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed	
12b. KIND OF BUSINESS OR INDUSTRY Retail Clothes							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Krauk				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Altman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-09-4770		17. INFORMANT ADDRESS Mr. P.W. Baker 3718 Beech Ave. 21211			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Melastole Bronchogenic Carcinoma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 14 , 19 84 , to 12/22 , 19 84 , that (I) (we) lost saw the deceased alive on 12/19 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. K. Yorkoff MD				DEGREE MD		22c. DATE SIGNED 12/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. K. Yorkoff MD				22e. ADDRESS 7600 Osler Dr. 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-24-84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 27 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 4 4 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LILLIAN BALK			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 3, 1984			2b. HOUR 2 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9X 76 1900		6. AGE (IN YEARS (LAST BIRTHDAY)) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6417 WESTERN RUN DR. (21215)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 6417 WESTERN RUN DR. (21215)							
14. FATHER'S NAME FIRST MIDDLE LAST MATISYUHU YANKELOVITZ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHAYA SARA UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-74-9745		17. INFORMANT MR. LOUIS BALK			
		6320 PEARCE AVE. BALTO., MD 21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSELEKTIC HEART DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) OLD MYOCARDIAL INFARCTION;							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JULY 1979 to 12/3/84 , that (I) (we) lost saw the deceased alive on 11/12 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE BERNARD RUBIN				22c. DATE SIGNED 12/3/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD RUBIN	
22e. ADDRESS 3502 CROYDON RD. (21207)							
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL		23b. DATE 12/4/84		23c. NAME OF CEMETERY OR CREMATORY BETH HAMEDROSH HAGODOL		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE, BALTO., MD.	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)				25a. DATE REC'D. BY REGISTRAR DEC 7 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JULIA STEINBERG BARLOW			2a. DATE OF DEATH MONTH 12 DAY 26 YEAR 84			2b. HOUR 01:50 AM			
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH 8 DAY 29 YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital of Baltimore				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME MAKER	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2910 TERRY DR. (21209)	
14. FATHER'S NAME FIRST JOSEPH MIDDLE LEVENSON LAST LEVITHAN				15. MOTHER'S MAIDEN NAME FIRST ROSE MIDDLE BELLE LAST LEVITHAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-36-9975		17. INFORMANT ADDRESS NORMAN F. STEINBERG 3412 FIELDING RD. (21208)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema / Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Ischemic Heart Disease (11 midnight to 1:50 AM) DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO: WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from JAN 12-26-84 19 to 1:50 AM 12-26-84 19, that (I) (we) lost saw the deceased alive on _____ 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph Salmon, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12.26.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Salmon				22e. ADDRESS Sinai Hospital Baltimore					
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE DEC. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MENS CEM		23d. LOCATION BALTIMORE, BALTIMORE, MD.		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)						25a. DATE REC'D. BY REGISTRAR JAN 3 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 4 2

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles M. Bandiere			2a. DATE OF DEATH MONTH 12 DAY 26 YEAR 84			2b. HOUR 0737A					
3. SEX male		4. RACE Cauc		5. DATE OF BIRTH MONTH May DAY 29 YEAR 1892		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		7b. IF UNDER 14 HRS HOURS MIN. 	
7a. BIRTHPLACE (COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of MD Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Owner			12b. KIND OF BUSINESS OR INDUSTRY Real Estate Co.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4901 Carroll Manor Rd. 21013					
14. FATHER'S NAME FIRST John MIDDLE LAST Bandiere				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST DeBella							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-01-7809		17. INFORMANT ADDRESS Betty Widerman- Same as #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest 8809 DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN stem herniation DUE TO, OR AS A CONSEQUENCE OF (c) subdural hematoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0730-0737 13 hrs 13 1/2 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 545 P.M. 12 25 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) fell down stairs					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 6:30 PM 12-25-84 to 0745 AM 12-26-84 , that (1) (we) lost saw the deceased alive on 12-26-84 , and that in (1) (our) opinion death resulted from the above and from the causes stated above, (1) (we) did (did not) view the body after death.											
22b. SIGNATURE Ronald Klenotic				DEGREE DDS		ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-26-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald Klenotic				22e. ADDRESS DDS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-28-84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park				23d. LOCATION, CITY OR TOWN COUNTY STATE Woodlawn, Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. ADDRESS Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR DEC 31 1984		25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall					

8 4 3 5 4 5

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STANDARD REPORT TO CONGRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 4 4 3

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Viola			2a. DATE OF DEATH MONTH DAY YEAR December 5, 1984			2b. HOUR 3:52A		
3. SEX FEMALE			4. RACE COL			5. DATE OF BIRTH MONTH DAY YEAR 2-8-1900		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. AGE (IN YEARS LAST BIRTHDAY) 84		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY BALTA.			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Dixon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Dixon			13d. STREET ADDRESS / ZIP CODE 449 WALTON CT 21201		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217057961			17. INFORMANT ADDRESS Mrs DIXIE BANKS 449 WALTON CT		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause Undetermine DUE TO, OR AS A CONSEQUENCE OF (b) Possible Cerebrovascular accident, cannot be excluded DUE TO, OR AS A CONSEQUENCE OF (c) due to Partial Autopsy.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 5, 1984 , to December 5, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 5, 1984 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.								
22b. SIGNATURE Patricia Weber, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/6/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia Weber, M.D.						22e. ADDRESS c/o Maryland General Hospital		
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL			23b. DATE 12-10-84			23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD
24. FUNERAL DIRECTOR NAME Joseph L. Russ 2222 W						25a. DATE REC'D. BY REGISTRAR DEC 14 1984		
						25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 4 4

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST WALTER	MIDDLE D.	LAST BANKS	2a. DATE OF DEATH MONTH DAY YEAR 12/16/84		2b. HOUR 8 50 P.M.		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2 11 02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Winnie Tenn		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN					
16a. SOCIAL SECURITY NO. 214-93-9379		17. INFORMANT ADDRESS Queritta Banks 1615 W. Caroline St							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Right Middle Lobe Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>12-16</u> , 19 <u>84</u> , to <u>12-16</u> , 19 <u>84</u> , that (2) (we) last saw the deceased alive on <u>12-16</u> , 19 <u>84</u> , and that (3) (our) opinion death occurred on the date and hour and from the causes stated above; that (4) (we) did not view the body after death.									
22b. SIGNATURE Jecamine S. Saunders MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-16-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jecamine Saunders					22e. ADDRESS Mercy Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/21/84		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR Wm C March F.H. 1101 E. North Ave.					25a. DATE REC'D. BY REGISTRAR DEC 18 1984		25b. REGISTRAR'S SIGNATURE John Davidson Saunders		

BP

CHURCHILL

1911



WATER COTTON

REG. NO.

MEDICAL CERTIFICATION

DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

DHMH - 17
(VR A15 ME (5))

20X6 0000418103 2007

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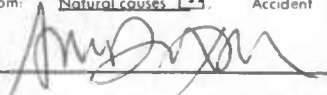
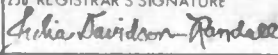
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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

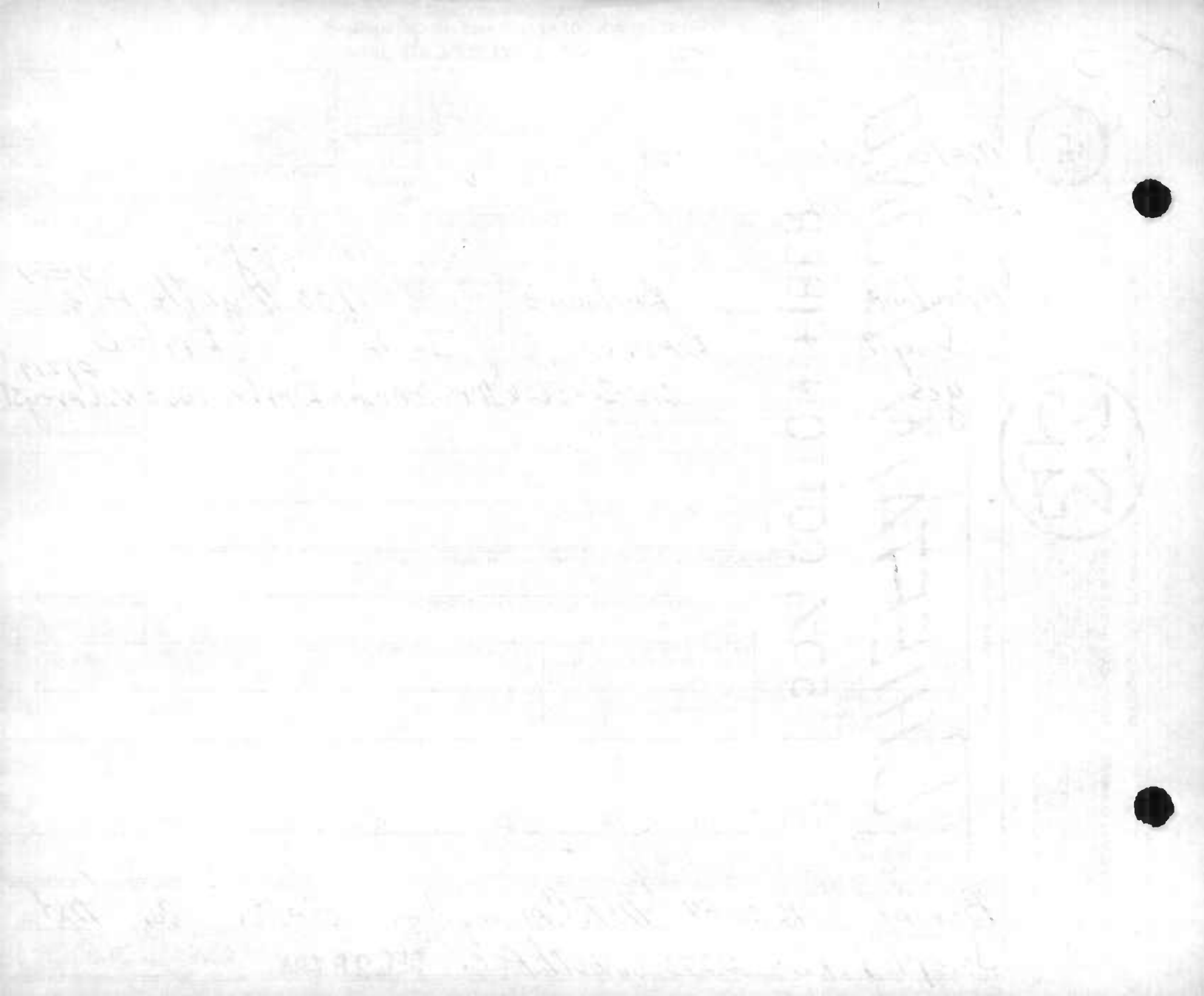
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) NATHANIEL BARBER			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12 4 19 84			2b. HOUR M 4:02 P 00			
3. SEX male	4. RACE Col.	5. DATE OF BIRTH MONTH DAY YEAR 5-13-34	6. AGE (IN YEARS) (LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 12 14 19 84			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1100 Myrtle Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Barber			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Idola Barber			13e. STREET ADDRESS 1100 Myrtle Ave. 21201			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 515-36-5656		17. INFORMANT Mrs. Marian Barber			ADDRESS 1560 N. Carey St. 21217	
CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure disorder DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 12-15-84			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-20-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. Md.		
24. FUNERAL DIRECTOR NAME Joseph L. Russ ADDRESS 2222 W. North Ave.			25a. DATE REC'D. BY REGISTRAR DEC 28 1984			25b. REGISTRAR'S SIGNATURE 			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE BUREAU AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

3 2 4 4 7

1. DECEASED NAME (TYPE OR PRINT) WALTER L. BARKSDALE			2a. DATE OF DEATH MONTH DAY YEAR 12/4/84		2b. HOUR 1033 P.M.
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 7 17 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Halifax Co., Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 1		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN BAUTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Barksdale		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Crews			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 231-12-2274		17. INFORMANT ADDRESS Louise D. Barksdale 2523 Boarman Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 84 , to 12/4 , 19 84 , that (I) (we) lost saw the deceased alive on 12/4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE BG Michael MD		DEGREE		22c. DATE SIGNED 12/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BG MICHAEL MD.		22e. ADDRESS SINAI HOSPITAL OF BALTIMORE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 12/7/84		23c. NAME OF CEMETERY OR CREMATORY Meadville Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Halifax Co., Va.					
24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 Liberty Hgts. Ave.				25a. DATE REC'D. BY REGISTRAR DEC 5 1984	
				25b. REGISTRAR'S SIGNATURE	

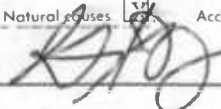
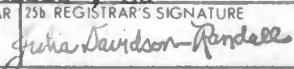
BP



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

3 2 4 4 8
REG. NO.

**1- FOR
STATE
REGISTRAR**

1. DECEASED NAME (TYPE OR PRINT) George W. Barnes				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12/ DAY 8/ YEAR 1984		2b. HOUR 4:02	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 3/ DAY 7/ YEAR 1919	6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0	7c. DATE PRONOUNCED DEAD 12/ 8/ 1984	7d. HOUR 4:02	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY 0
13a. STATE Md				13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS 301 McMecken St. 21216	
14. FATHER'S NAME FIRST Samuel MIDDLE Langford LAST Langford				15. MOTHER'S MAIDEN NAME FIRST Maine MIDDLE Langford LAST Langford			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 33958557				16b. SOCIAL SECURITY NO. 212-16-9602		17. INFORMANT ADDRESS Pat, Anthony., 3405 Maryvale Rd. 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION _____				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 12/9/84	
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/12/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forrest Va		23d. LOCATION CITY OR TOWN Owings Mills, Md COUNTY _____ STATE _____	
24. FUNERAL DIRECTOR NAME Law Funeral Home ADDRESS 4611 Park Heights Ave. 21215				25a. DATE REC'D. BY REGISTRAR DEC 10 1984		25b. REGISTRAR'S SIGNATURE 	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE
NEW YORK 17, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 4 4 9 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James L. Barnes				MONTH DAY YEAR 12 22 84			
3. SEX Male				7b. HOUR 10 15 P M			
4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 11 26 16		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7a. UNDER 1 YEAR MONTHS DAYS 7b. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 2230220			
10. CITY OR TOWN OF DEATH Baltimore				12b. KIND OF BUSINESS OR INDUSTRY MD Daycare			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John C. Deaton				13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. COUNTY Baltimore 13d. CITY OR TOWN Baltimore 13e. STREET ADDRESS / ZIP CODE 1916 W. Haynes St. 21223			
14. FATHER'S NAME FIRST MIDDLE LAST L. L. Barnes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL Davis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 226 14 5150			
17. INFORMANT ADDRESS SWIRLEY Taylor 1916 W. Haynes St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest. DUE TO, OR AS A CONSEQUENCE OF (b) end stage - recurrent CA - Epiglottitis. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 21, 19 84, to Dec 22, 19 84, that (I) (we) last saw the deceased alive on Dec 22, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) YVETTE OQUENDO				22c. DATE SIGNED 12/23/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YVETTE OQUENDO				22e. ADDRESS John L. Deaton Medical Center Charles St. Balto, Md.			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 12/28/84		23c. NAME OF CEMETERY OR CREMATORY MD Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE MD	
24. FUNERAL DIRECTOR NAME W. D. Hayes 635 N. Gilman St.				25a. DATE REC'D. BY REGISTRAR DEC 26 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

①

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the
and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
Your obedient servant,
[Signature]

Very truly yours,
[Signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 4 5 0
REG. NO.1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Mary Frances Barnes			2a. DATE OF DEATH MONTH DAY YEAR 12/26/89			2b. HOUR 4:57 AM				
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 12 18 66		6 AGE YEARS (LAST BIRTHDAY) 66		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unk		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md.			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 740 Poplar Street 2176	
14 FATHER'S NAME FIRST MIDDLE LAST Walter Jennings			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virgie Harden							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unk			16b. SOCIAL SECURITY NO. 215-12-9712		17 INFORMANT ADDRESS Willie's Jennings 408 Edsall					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardio. Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b): Chronic renal failure DUE TO, OR AS A CONSEQUENCE OF (c): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/26/89 , 19____, to 12/26/89 , 19____, that (I) (we) last saw the deceased alive on 12/26/89 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death .										
22b. SIGNATURE [Signature]			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.K. Parosh			22e. ADDRESS Lutheran hosp							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/30/84		23c. NAME OF CEMETERY OR CREMATORY Family Plot		23d. LOCATION CITY OR TOWN COUNTY STATE Victoria, Va.			
24. FUNERAL DIRECTOR NAME Wm C March F/H,					ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 15 is marked any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 5 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Doris Callahan Barnett.					2a. DATE OF DEATH MONTH DAY YEAR 12 15 84			2b. HOUR MIN. 13:40			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2 03 81		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS		7. UNDER 1 YEAR MONTHS DAYS 12 15		8. UNDER 24 HRS. HOURS MIN. 13 40	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE SCHOOL TRAUMA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS			12b. KIND OF BUSINESS OR INDUSTRY Restaurants		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Talbot		13c. CITY OR TOWN St. Michaels		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 809 TALBOT ST 21663	
14. FATHER'S NAME FIRST MIDDLE LAST Charles F. Callahan Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Boris CALLAHAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----		17. INFORMANT ADDRESS St. Michaels, Md. 21663							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Closed Head Injury 8199 DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock, Closed Head Injury. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Insipidus.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 1 12 10 1984			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Motor Vehicle Accident.					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) STREET.			21f. LOCATION STREET CITY OR TOWN COUNTY STATE ST. MICHAELS MD					
22a. I certify that (I) (this hospital) attended the deceased from 12/10/84 , 19 84 , to 12/15/84 , 19 84 , that (I) (we) last saw the deceased alive on 12/13 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eric L. Bhoomi Field						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric L. Bhoomi Field						22e. ADDRESS University Hospital Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 18, 1984		23c. NAME OF CEMETERY OR CREMATORY Green Mount			23d. LOCATION CITY OR TOWN COUNTY STATE Hillsboro Caroline Md.			
24. FUNERAL DIRECTOR NAME Hansen E. Leonard						ADDRESS St. Michaels, Md.		DATE REC'D. BY REGISTRAR DEC 24 1984			

BP. _____

11-4-50 11-4-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The last cause of death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury or other traumatic event, the medical examiner must be called on.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 4 5 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN F. BARRETT			2a. DATE OF DEATH MONTH DAY YEAR DEC. 12, 1984		2b. HOUR 12:01 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 24 1912	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. J.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tavern Owner		12b. KIND OF BUSINESS OR INDUSTRY Self Employ.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE N.J.		13b. CITY OR TOWN Jersey City	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 285 Pearsall Ave. 07305	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Barrett		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie McCall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 149-28-5025	17. INFORMANT ADDRESS McLaughlin F.H. Jersey City, N.J.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC - pulmonary ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) E. coli Sepsis					4 days	
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Acute Renal Failure, Hypoxemia, Diffuse Pulmonary Infiltrates						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/15/84 , 19 84 , to 12/12 , 19 84 , that (I) (we) last saw the deceased alive on 12/12 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.						
22b. SIGNATURE Mark Cooper MD		DEGREE MD		22c. DATE SIGNED 12/12/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK S. COOPER MD		22e. ADDRESS Johns Hopkins Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial	23b. DATE 12-15-84	23c. NAME OF CEMETERY OR CREMATORY Holy Cross	23d. LOCATION CITY OR TOWN COUNTY STATE N. Arlington N. J.			
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co., Balto., Md.			25a. DATE REC'D. BY REGISTRAR DEC 13 1984			
			25b. REGISTRAR'S SIGNATURE John J. Ford			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 5 3

REG. NO.

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY DOLORES BARTLES		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 15, 1984		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1914		6. AGE (IN YEARS (LAST BIRTHDAY)) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6009 The Alameda		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 6009 The Alameda 21239		14. FATHER'S NAME FIRST MIDDLE LAST George Adam Evering		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Anna Kuhn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 086-16-8036D		17. INFORMANT 5424 Remmell Ave. Estelle C. Jendrek Baltimore, Md. 21206			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SMALL CELL CARCINOMA of the LUNG.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from _____, 19____, to <u>12/15</u> , 19 <u>84</u> , that (b) (we) last saw the deceased alive on <u>12/17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John Fetting</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/16/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Fetting		22e. ADDRESS Johns Hopkins Oncology Center.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/18/84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md.	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Balto., Md. 21212		25a. DATE RECEIVED BY REGISTRAR DEC 19 1984		25b. REGISTRAR'S SIGNATURE	

BP

BP _____

DHMM-16 30M 2/80
(VRA 15, 4)

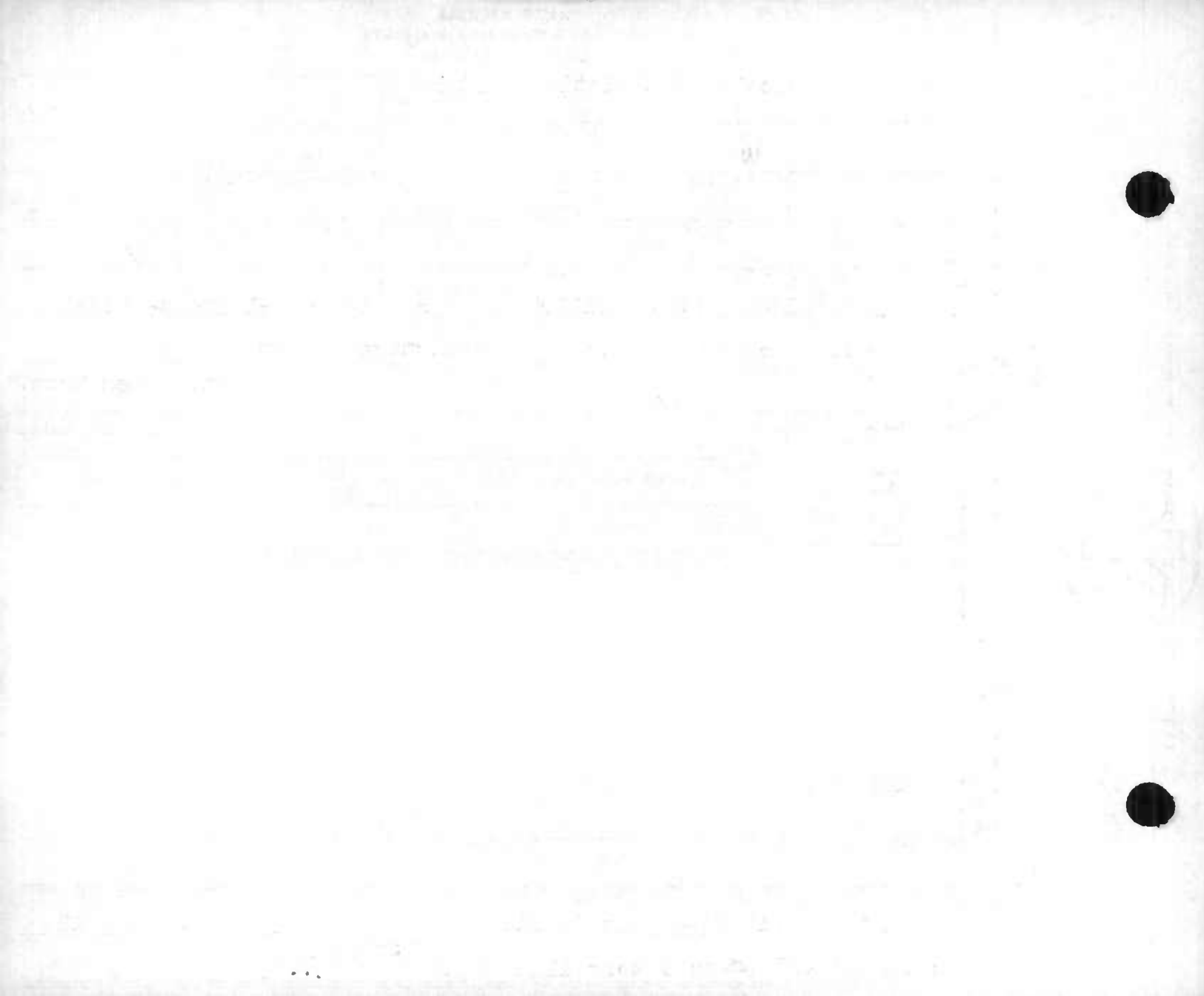
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					3 2 4 5 4 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST Nicole MIDDLE Christine LAST Bartsh BABY GIRL BARTSH					2a. DATE OF DEATH MONTH DAY YEAR 12/22/84 12 22 84				2b. HOUR 2:40 PM	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 22 84		6. AGE (IN YEARS LAST BIRTHDAY) 14 Years		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) n/a		12b. KIND OF BUSINESS OR INDUSTRY n/a		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 13 Rognel Avenue 21228		
14. FATHER'S NAME FIRST MIDDLE LAST Terrance Gordon Bartsh					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Ruth Haeg					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS Lilly Lin (Dr. Lilly Lin) St. Agnes Hosp.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary failure DUE TO, OR AS A CONSEQUENCE OF: (b) extreme prematurity DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lilly Lin				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-22-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lilly Lin				22e. ADDRESS 900 Canton Ave, Baltimore, 21229						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-26-84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD				
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home				ADDRESS Catonsville Md.		25a. DATE REC'D. BY REGISTRAR DEC 27 1984		REGISTRAR'S SIGNATURE Davidson-Randall		



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 5 5

1 - FOR
STATE
REGISTRAR

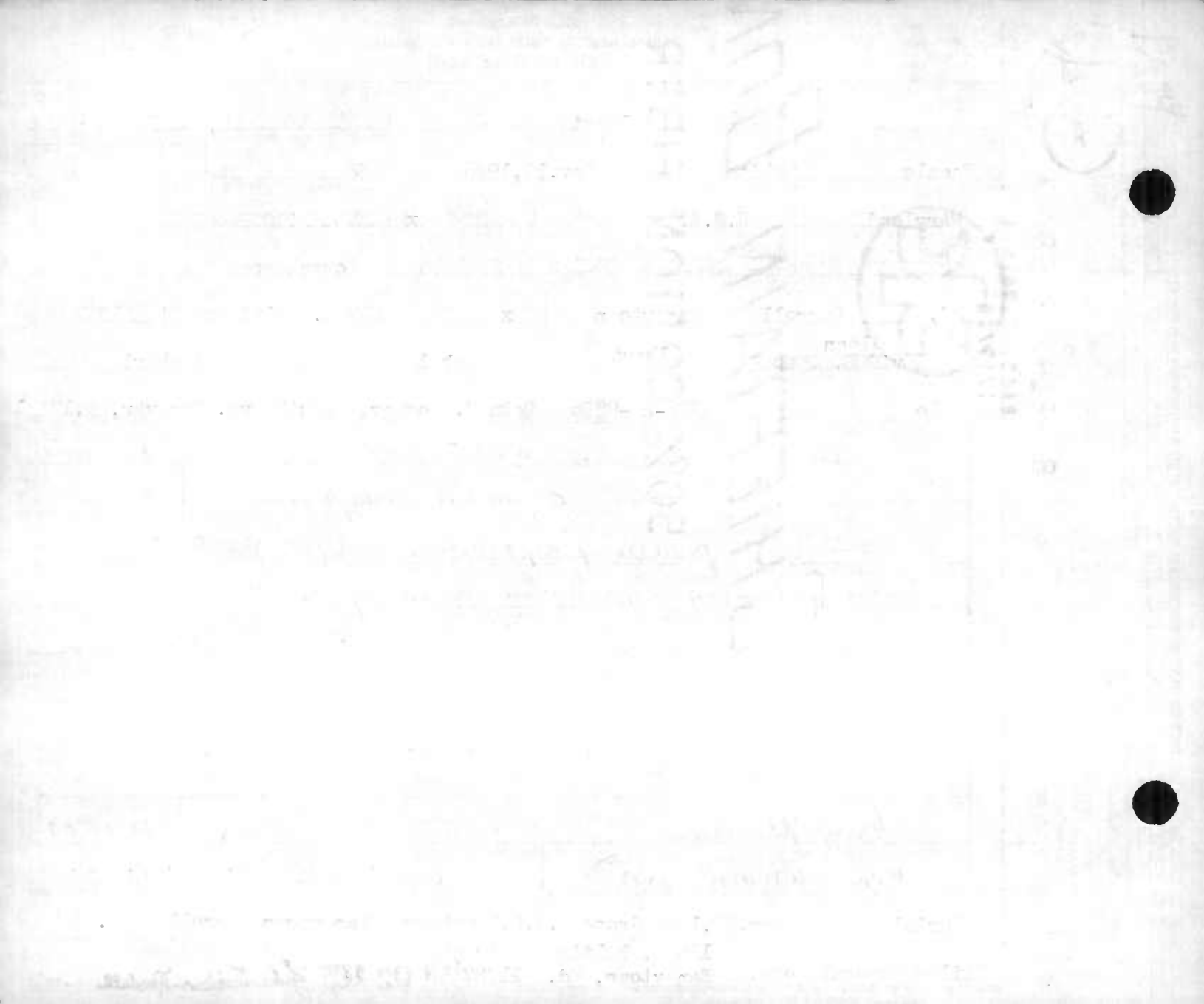
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VIRGINIA Albert BASS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 25 1984		2b. HOUR P 9:00 M
1. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1926		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 58	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Carroll	13c. CITY OR TOWN Taneytown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Glenn Albert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Lambert			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-20-9856		17. INFORMANT ADDRESS Deka V. Topper, 200 Ruth Ave. Hanover, Pa. 17331	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (b) cardiac conduction arrhythmias					3 days
DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary hypertension and post-operative					3 days.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Severe pulmonary hypertension secondary to ASD.					
19a. DATE OF OPERATION 12/22/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED acute cholecystitis		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 12/21/84 19, to 12/25/84 19, that (I) (we) last saw the deceased alive on 12/20/84 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)					
22b. SIGNATURE John McTear		DEGREE		22c. DATE SIGNED 12.25.84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MCNEAL MD.		22e. ADDRESS 600 N. WOLFE ST. BALTO, MD. JOHNS HOPKINS HOSPITAL 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 29, 1984		23c. NAME OF CEMETERY OR CREMATORY Grace U.U.C. Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown Carroll Md.					
24. FUNERAL DIRECTOR NAME Skiles Funeral Home,		ADDRESS 136 E. Baltimore Street Taneytown, Md. 21787		25a. DATE REC'D. BY REGISTRAR JAN 02 1985	
25b. REGISTRAR'S SIGNATURE John Davidson Russell					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial transit permit. These pages remain the property of the State Dept. of Health and Mental Hygiene and should be returned to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. If item 21 is marked or item 18 shows any injury, or other traumatic event, no dissection or autopsy should be performed without the written consent of the State Dept. of Health and Mental Hygiene.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						3 2 4 5 6			
1. FOR STATE REGISTRAR						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WADE BATCHELOR						2a. DATE OF DEATH MONTH 12 DAY 27 YEAR 84 2b. HOUR 8:23A M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 07 DAY 22 YEAR 22		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS 00 DAYS 00	
7a. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Fairfield, NC		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD			
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1126 N. Stockton St. 21217	
14. FATHER'S NAME FIRST John MIDDLE Batchelor LAST Batchelor				15. MOTHER'S MAIDEN NAME FIRST Angie MIDDLE Tucker LAST Tucker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 246248410		17. INFORMANT MARSHA Smith				ADDRESS 1126 N. Stockton St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp. failure DUE TO, OR AS A CONSEQUENCE OF (b) SURGICAL RESECTION of esophageal ca. DUE TO, OR AS A CONSEQUENCE OF (c) NONRE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION 12-26-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of esophagus		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 7 , 19 84 , to DECEMBER 27 , 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 27 , 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE N. Nachlas				DEGREE M.D.				22c. DATE SIGNED 12-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nathan Nachlas				22e. ADDRESS VAMC, Baltimore, Maryland 21218					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1/7/85		23c. NAME OF CEMETERY OR CREMATORY V.A. Camp. Salford		23d. LOCATION CITY OR TOWN Carrboro, NC COUNTY W.C. STATE NC			
24. FUNERAL DIRECTOR W. Carroll		24b. ADDRESS 117 W. North Ave		25a. DATE REC'D. BY REGISTRAR JAN 2 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Ripstein			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 4 5 7 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) John R. Bates			
2a. DATE OF DEATH MONTH DAY YEAR 12-1-84 2b. HOUR 2 AM							
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3-15-33		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Federal Hill Ngs. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md. 13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1937 Penna. AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. 216-30-0441				17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of oropharynx DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) S.P. Respiratory insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) S.P. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo 2 wks							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: S.P. Tracheostomy 10/20/84							
19a. DATE OF OPERATION 10/20/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/15 , 19 84 , to 11/30 , 19 84 , that (I) (we) lost saw the deceased alive on 11/15/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Amatun H. Naheem DEGREE MD				22c. DATE SIGNED 12/1		22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMATUN H NAEEM	
22e. ADDRESS 501 Dolphin St Baltimore				22f. ADDRESS 501 Dolphin St Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR Leroy A. Sytt 4600 Liberty St				25a. DATE REC'D. BY REGISTRAR 3 1984 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 5 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Carol E. Bauer			2a. DATE OF DEATH MONTH 12 DAY 24 YEAR 84			2b. HOUR 120 P.M.			
3. SEX Female		4. RACE caucasian		5. DATE OF BIRTH MONTH 10 DAY 31 YEAR 47		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS.		7. IF UNDER 1 YEAR MONTHS 31 DAYS 31	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.			
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DATA PROCESSING		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	

13a. STATE MD			13b. COUNTY Balto			13c. CITY OR TOWN White Marsh			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5711 Carrington Dr 21162		
14. FATHER'S NAME FIRST UNKNOWN MIDDLE ROBERTSON LAST ROBERTSON						15. MOTHER'S MAIDEN NAME FIRST SARAH MIDDLE MACVEAN LAST MACVEAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO. 218-52-9665			17. INFORMANT CHESTER BAUER (HUSBAND)			ADDRESS SAME ADDRESS		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
DUE TO, OR AS A CONSEQUENCE OF (b) metastatic involvement of lung		several mos.	
DUE TO, OR AS A CONSEQUENCE OF (c) breast cancer		2 yrs	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **NO**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/28 , 19 84 , to 12/24 , 19 84 , that (1) (we) last saw the deceased alive on 12/24 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							

22b. SIGNATURE Phyllis P. Wintney MD			DEGREE MD			22c. DATE SIGNED 12/24/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Sinai Hosp., Greenspring Belvedere					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW MEM. PARK		23d. LOCATION CITY OR TOWN BALTIMORE COUNTY MD. STATE MD.	
24. FUNERAL HOME NAME SPHIMUNEK FUNERAL HOME, INC. ADDRESS 9705 BELAIR RD., BALTO. MD. 21236				25a. DATE REC'D. BY REGISTRAR DEC 28 1984 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 4 5 9

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HATTIE MAY BEALL			2a. DATE OF DEATH MONTH DAY YEAR 12 21 84			2b. HOUR 3:15 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 19, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Phoenix		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William H. Wells			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Davis			16. STREET ADDRESS / ZIP CODE 3809 Sweet Air Rd. 21131			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-2820D		17. INFORMANT Natalie M. Marks			17b. ADDRESS Same		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Bowel				3 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Post MI & new atrial fibrillation + embol.				3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) HTN					
19a. DATE OF OPERATION 12/21/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/19/84 to 12/21/84 , that (I) (we) lost saw the deceased alive on 12/21 19 84 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Susan G. Weiner MD		DEGREE		22c. DATE SIGNED 12/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SUSAN G. WEINER		22e. ADDRESS UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 24, 1984		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard Co., Md.		23e. DATE RECEIVED BY REGISTRAR DEC 27 1984			
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212		25. REGISTRAR'S SIGNATURE			

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State of Illinois

County of Cook

City of Chicago

County of Cook

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County of Cook

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 4 6 0
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William Beck		2a. DATE OF DEATH MONTH DAY YEAR 12 29 1984		2b. HOUR 2:30^a M	
3. SEX Male	4. RACE C. Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 8 12 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Cent.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wholesaler		12b. KIND OF BUSINESS OR INDUSTRY Produce
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21224 2616 E. Fairmount Ave.
14. FATHER'S NAME FIRST MIDDLE LAST William Beck		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 215-24-9322		17. INFORMANT 2038 Maleady Dr. Herndon, Va. 22070	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypocardial Ischemia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Peptic Ulcer Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael J. [Signature]		DEGREE PHYSICIAN		22c. DATE SIGNED 12/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/2/85		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME B. Dabrowski & Son		ADDRESS 2818 E. Baltimore St.		25a. DATE REC'D. BY REGISTRAR DEC 31 1984	
		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 6 1
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		2b. HOUR	
MORRIS		BECKER		12 1- 84		11:35A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		MONTH DAY YEAR		81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
RUSSIA		U.S.A.				CITY OF BALTIMORE MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		LEVINDALE HEBREW GERIATRIC CTR		RETAIL STORE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		BALTIMORE		BALTIMORE			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
JACOB		BERNIE		NO		213-14-8997A	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MRS. BELLE KLOZE		6 POMONA NORTH APT. 7 (21208)		PART I. DEATH WAS CAUSED BY:			
				IMMEDIATE CAUSE (a)		PNEUMONIA	
				DUE TO, OR AS A CONSEQUENCE OF			
				(b)			
				DUE TO, OR AS A CONSEQUENCE OF			
				(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-2, 1984, to 12-1, 1984, that (I) (we) last saw the deceased alive on 12-1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
SE, H. T. W. A. R.				12-1-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE	
SE, H. T. W. A. R.		Levindale Hebrew Geriatric Center		DEC 7 1984		ma Davidson-Randall	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		12/2/84		OHR KNESSETH ISRAEL CEM. BALTIMORE		CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. CITY OR TOWN		24d. COUNTY	
SOL LEVINSON & BROS., INC.		6010 REISTERSTOWN RD. BALTO, MD 21215		BALTIMORE		MARYLAND	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 4 6 2
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		3:35 PM	
James A. Beegan		December 8, 1984			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Male	White	July 12, 1918	66	MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7c. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Ireland	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	3912 Beech Avenue (21211)		Chemist- Industrial		Hygienist
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	
Maryland		--	Baltimore	3912 Beech Avenue (21211)	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS	
Thomas Beggan		Anne Mac Donnell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
No		143-01-7290	Alice Rowe Beegan-3912 Beech Ave (21211)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Meloid, toxic cancer of colon</i>					
DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY	21f. LOCATION		
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>several years</i> 19____, to _____ 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
<i>Thomas Polesky</i>		<i>MD</i>			<i>12/19/84</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Thomas Polesky		611 Park Ave BALTO MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		12/11/84	Mt Airy Cemetery-Harrisontownship,		Allegheny Co., Penna.
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
A. Alan Seitz Funeral Home 3818 Roland Ave.				<i>Julia Kordon-Rodell</i>	

DEC 13 1984

No.	Name	Quantity	Value	Remarks
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

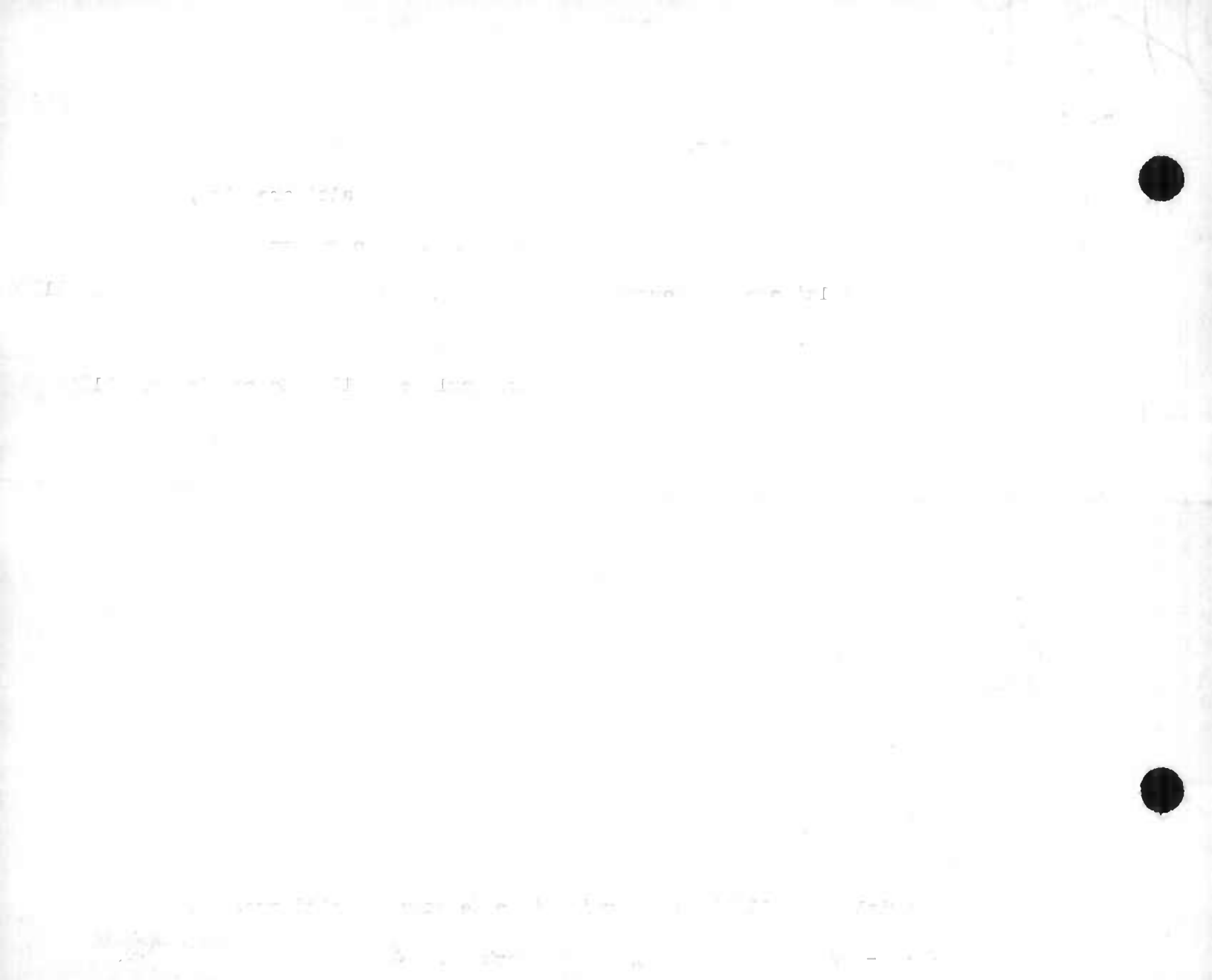
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the police notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 6 3	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Margaret A. Behm						2a. DATE OF DEATH MONTH DAY YEAR December 16 1984		2b. HOUR 10:17 AM			
3 SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 07 17		6 AGE (IN YEARS (LAST BIRTHDAY)) 67		7. IF UNDER 1 YEAR MONTHS DAYS 6		7b. IF UNDER 72 HRS HOURS MIN. 10:17	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1110 Concordia Dr. Bethesda MD 21204			
14 FATHER'S NAME FIRST MIDDLE LAST Charles E. Weichman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Anderson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-094-023		17 INFORMANT Mr. Carl Behm				ADDRESS 1110 Concordia Dr. 21204			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure, anemia, generalized metastasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of Uterus - metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Transitional Cell ca of bladder.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Sepsis 24 to 48 Hrs - E. coli											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on December 16 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Maria Eugenia Rodriguez MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec 16, 1984			
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Maria Eugenia Rodriguez MD						22e. ADDRESS 3001 S. Hendrick St. Bethesda MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/84		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24 FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.						ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR DEC 21 1984		25b. REGISTRAR'S SIGNATURE John J. Anderson	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 6 4

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN E BELLEIN			2a. DATE OF DEATH MONTH DAY YEAR 12 05 84		2b. HOUR 4:25 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB. 11 1931		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIRE FIGHTER	12b. KIND OF BUSINESS OR INDUSTRY WRESTLING
13a. STATE BALTIMORE			13b. COUNTY BALTIMORE	13c. CITY OR TOWN PARKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JAMES G. BELLEIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE E. BELLEIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 216-12-0001		17. INFORMANT ADDRESS FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESP. ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Cervical Spondylosis</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 MIN 10 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/5/84 to 12/5/84, that (I) (we) lost saw the deceased alive on 12/5/84, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Maddie M. Denker		DEGREE M.D.		22c. DATE SIGNED 12/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRADLEY M. DENKER		22e. ADDRESS 600 N. WALPST BALTIMORE MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIED		23b. DATE DEC 12 1984	23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL BURIAL GROUND		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTIMORE
24. FUNERAL DIRECTOR NAME S. H. CHAPMAN & SONS, INC.		ADDRESS 888 N. E. 10th St. BALTIMORE, MD 21201		25a. DATE REC'D. BY REGISTRAR DEC 7 1984	
				25b. REGISTRAR'S SIGNATURE John Richardson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be filed in the funeral director's office. It should be detached for use as the burial-transit permit. Then please remove the appropriate pages and take them to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner is to be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

PROPOST 101. If page 21 is marked as "None," all other information, including medical certificates, must be available for review at all times.

DHMH - 16 50M 4/B3
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 6 5					
FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
James				Bell		12/3/84								8:50 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
M		B		02 19 16		68		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
-?						Baltimore City MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				University Maryland											
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
MD				Baltimore		Owings Mills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rosewood Lane 21117					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Eugene				Grace											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
unknown				216445876											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Cardio pulmonary collapse															
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION				CITY OR TOWN COUNTY STATE			
AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET							
22a. I certify that (I) (this hospital) attended the deceased from 12/3 1984, to 12/3 1984, that (I) (we) last saw the deceased alive on 12/3 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
Papuchis												12/3/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
PAPUCHIS				11652 Laurel Dr											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Removal				12/6/84								CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR				25a. DATE RECEIVED BY FUNERAL DIRECTOR				25b. REGISTRY OF DEATHS							
NAME				ADDRESS											
Anatomy Board				Balto., Md.											



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1913/14



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 6 6

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		2b. HOUR	
WILLIAM H. BELL				12 16 84		9:22 ^{PM}	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE	WHITE	MONTH DAY YEAR		68 YRS		MONTHS DAYS HOURS MIN.	
05 02 16							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	U.S.A.			BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	1927 HARMAN AVENUE, 21230			MOULD MAKER		GLASS MFG.	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MARYLAND	---	BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1927 HARMAN AVENUE, 21230			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
WILLIAM H. BELL JR.		VIRGINIA M. CAIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		216-01-7326		DOROTHY IVY BELL 1927 HARMAN AVENUE, 21230			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) LUNG CANCER							1 YEAR
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 1-29-19-72, to 12-16-19-74, that (1) (we) last saw the deceased alive on 12-16-19-74, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
MARC POSNER, M.D.		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/17/74			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
MARC POSNER, M.D.		107 E. WEST STREET					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
ENTOMBMENT		12-20-84		LOUDON PK. MAUSOLEUM		BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE.		12-19-1984		John Davidson	



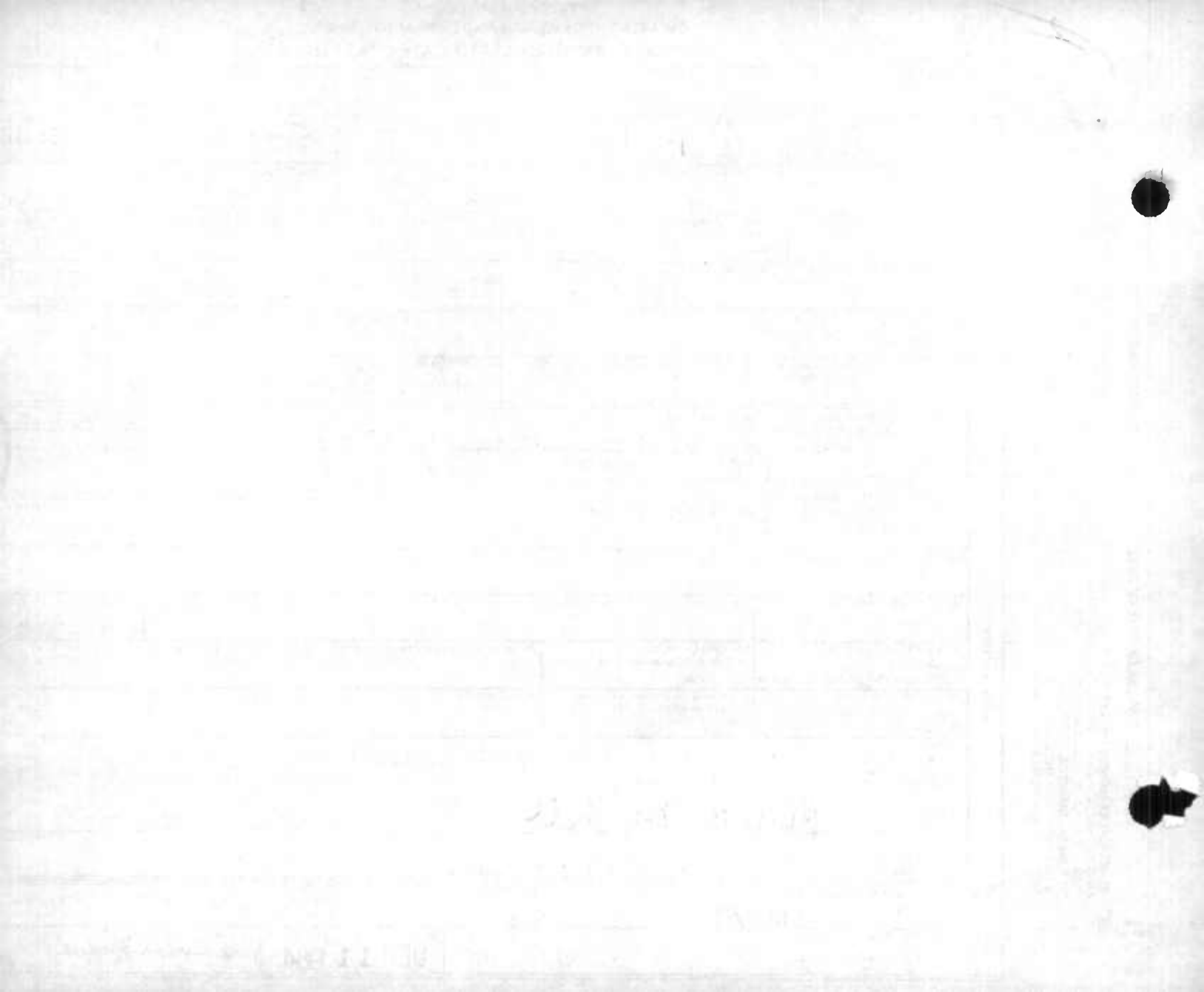
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 4 6 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR							
WILLIAM		HENRY		BELL				XX		12-2-84						M							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR							
male	black	8 5 1904		80		YRS.				12-3-84						3:01P							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Va		U S A														Baltimore City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Baltimore		1114 N. Eden Street																					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21213													
Md				Baltimore		YES X NO		1114 N. Eden Street															
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST				FIRST MIDDLE LAST																			
William Bell				Martha Davis																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
No				N/A				Betty Solomon				604 E. Eager Street											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART I DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																							
(b) _____																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) _____																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?											
												YES NO X											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				HOUR A.M. MONTH DAY YEAR																			
				P.M. 19																			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				COUNTY				STATE			
WHILE AT WORK NOT WHILE AT WORK																							
22a. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner																							
Actual Signature: <u>Margarita A. Korell</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 12-4-84																							
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS																							
Margarita A. Korell, M.D. 111 Penn Street																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY				STATE			
Burial				12/8/84				Mt Calvary Cem				Anne Arundel Co				Md							
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
William C. March F/H 1101 E. North Ave										DEC 11 1984				<u>Julia Davidson-Randall</u>									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO. 68

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELEANOR W. BENKE			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12-3-84		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12-31-23	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 60	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-3-84
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		10. CITY OR TOWN OF DEATH Baltimore			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5509 Daywalt Avenue 21206		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria-Retired			
12b. KIND OF BUSINESS OR INDUSTRY City of Balto		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13b. STREET ADDRESS 5509 Daywalt Ave.-21206		14. FATHER'S NAME FIRST MIDDLE LAST Clements Rupp			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rich		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 217-14-9114		17. INFORMANT ADDRESS Mr. Richard N. Benke - 5509 Daywalt Ave. 21206			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) Assistant		DATE SIGNED 12-3-84	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-6-84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus	
23d. LOCATION CITY OR TOWN Balto. Md.		COUNTY STATE			
24. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Rd. - 21206		25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2. IF YOU FILE WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



12-21-58

12-21-58

21-21-58

21-21-58

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21-21-58

21-21-58



21-21-58

21-21-58

21-21-58

21-21-58

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Film 0599 item 17

FOR 1/7/85 rja
1- STATE REGISTRAR 2/19/85 #600

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 4 6 9
REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
Bonnie C. Bennett						12-28 1984						M							
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR					
Female		White		8 7 52		32 YRS.						12-28 1984		7:35 P. M.					
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				U.S.A.								Baltimore City, MD							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				Francis Scott Key Medical Center															
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland												Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		258 Baltimore Ave. 21222	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						16. ADDRESS							
John O. Seekford						Grace E. Dority													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT							
No						217-54-2563						Grace E. Bender Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Salicylate intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12/28 1984				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
								subject ingested drug											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9 Wells Ave. Balto., Md.											
22a. I certify that took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 12-29-84							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Dennis F. Smyth, M.D.				111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				1/2/1985				Gardens Of Faith				Baltimore Maryland							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE							
Duda-Ruck, Inc.				7922 Wise Avenue Dundalk, MD. 21222								JAN 2 1985 Julia Davidson-Randall							

RECEIVED

NOV 11 1900



Received by Special Agent

film 600 item 6
1-816/85 rja
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 4 7 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12-3-84			MONTH DAY YEAR			2b. HOUR		
3. SEX Male			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 2 11 16			6. AGE (IN YEARS) (LAST BIRTHDAY) 68 YRS.			IF UNDER 1 YR. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4800 blk. Park Hgts.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 5018 Pembridge Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 231-09-6735			17. INFORMANT ADDRESS Dorothy Snowden 5018 Pembridge Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>Margarete A. Korell</i>			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 12-4-84					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/10/84			23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA			23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H			ADDRESS 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR DEC 6 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201



1st of April

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32471			
1. DECEASED NAME (TYPE OR PRINT) Foster W. Berry				2a. DATE OF DEATH MONTH DAY YEAR 12 22 84			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 04 1912		2b. HOUR 3:45 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
10. CITY OR TOWN OF DEATH Baltimore MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 5101 Quennsberry Ave.		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 5101 Quennsberry Ave. 21215			
13a. STATE MD		13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. 138-03-2514		17. INFORMANT ADDRESS Annie M. Simon 1026 Wilmot Ct.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) Cardiomyopathy				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF		(b) transient stroke					
DUE TO, OR AS A CONSEQUENCE OF		(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/14/84, 19 to 12/22, 1984, that (I) (we) last saw the deceased alive on 12/21/84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. B. Brem		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. B. Brem		22e. ADDRESS SINAI Hosp Balto MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/26/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR 12/27/84 REGISTRAR'S SIGNATURE John Davidson			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 7 2 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) James Berry					2a. DATE OF DEATH MONTH December DAY 8 YEAR 1984			2b. HOUR 3:09 A				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 9 DAY 10 YEAR 00		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1504 E. Oliver St. 21213			
14. FATHER'S NAME FIRST MIDDLE LAST 					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-01-4972		17. INFORMANT Mrs. Iona Combs			ADDRESS 1504 E. Oliver St. Balto., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) 												
DUE TO, OR AS A CONSEQUENCE OF (c) 												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Chronic Dementia, Neuro Syphilis, Sepsis												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 7, 1984 to December 8, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 8, 1984 , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.												
22b. SIGNATURE Keith I. Adams					DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/10/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith I. Adams, M.D.					22e. ADDRESS c/o Maryland General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 12/12/84		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md.					25a. DATE REC'D. BY REGISTRAR DEC 2 1984		25b. REGISTRAR'S SIGNATURE John Burden					



18th Street, New York

18th Street, New York

18th Street, New York

18th Street, New York

18th Street, New York

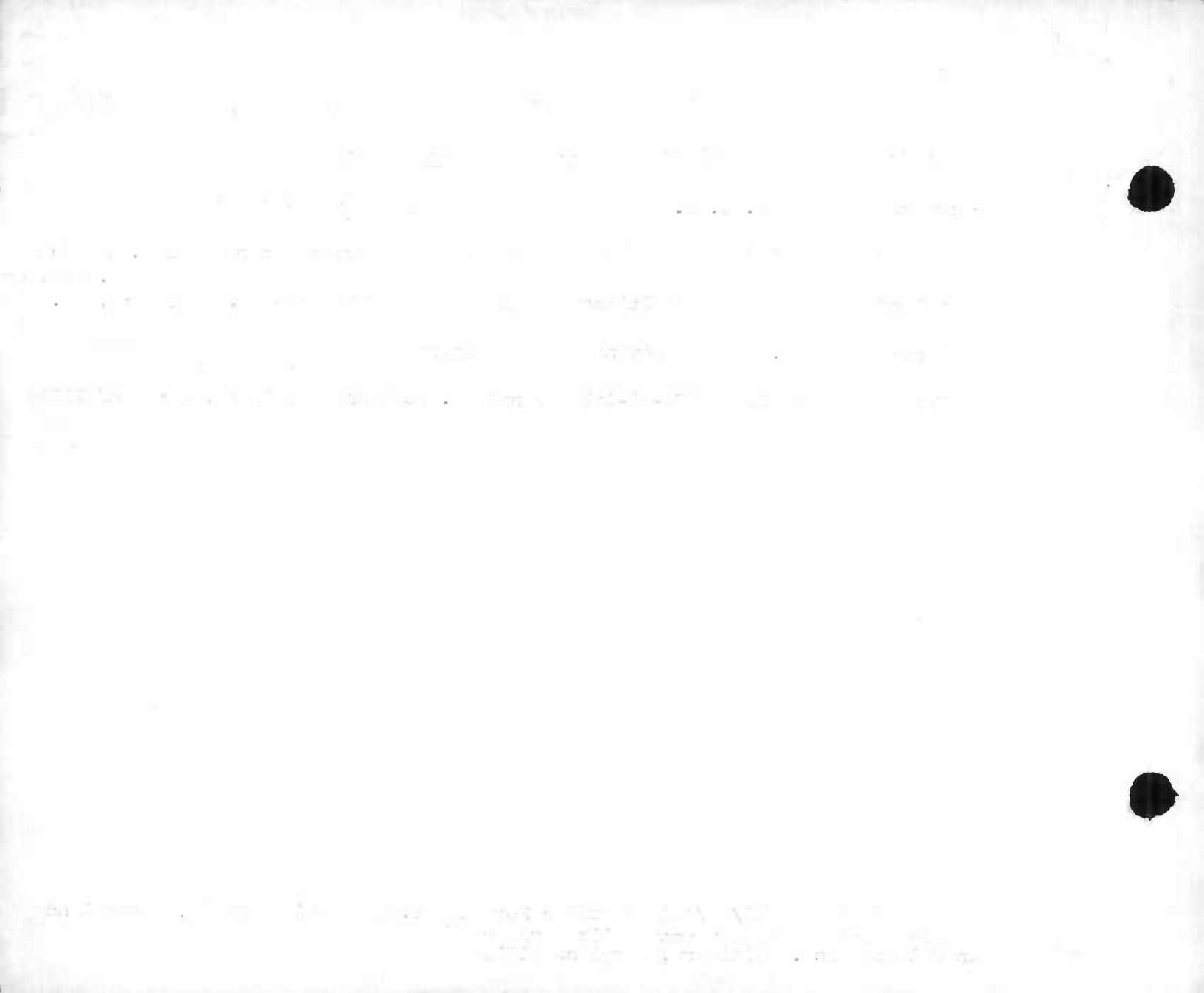
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					3 2 4 7 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) HAROLD H BEVANS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 4, 1984		2b. HOUR 7:00		A M		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11 12 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71	7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman		12b. KIND OF BUSINESS OR INDUSTRY Soc. Security		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Fannie B. Poulson 2318 Koko La. Baltimore, Md. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST George H. Bevans			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva Gaskins			16. ADDRESS 2318 Koko Lane Baltimore, Maryland 21216			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 220-03-1537		17. INFORMANT Fannie B. Poulson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CIRRHOSIS POSSIBLE HEPATOMA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-27 , 19 84 , to 12-4 , 19 84 , that (I) (we) lost saw the deceased alive on 12-4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kenneth J. Holroyd				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-4-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH HOLROYD				22e. ADDRESS JOHNS HOPKINS HOSPITAL BALTIMORE MD 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/1984		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Maryland			
24. FUNERAL HOME OR PERSON TO WHOM REMAINS WERE DELIVERED Nutter & Sons 2501 Gwynns Falls Parkway Funeral Home Inc. Baltimore, Maryland 21216				25a. DATE REC'D. BY REGISTRAR DEC 12 1984					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 7 4
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANDREW LEROY BEVERLY			2a. DATE OF DEATH MONTH DAY YEAR 12 05 84		2b. HOUR MIN. 8¹⁴ P
3. SEX Male	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 04 24 21 21		6. AGE (IN YEARS (LAST BIRTHDAY)) 63	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND			13c. CITY OR TOWN ST. LEONARD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Beverly			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET BAFFORD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-18-5947		17. INFORMANT ADDRESS HOSPITAL CHART	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIAC ARREST / SEVERE LOW OUTPUT**

DUE TO, OR AS A CONSEQUENCE OF

(b) **SEVERE LEFT VENTRICULAR FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **DIFUSE ATHEROSCLEROSIS, CORONARY ARTERY DISEASE**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

RENAL AND HEPATIC FAILURE / PANCREATITIS

19a. DATE OF OPERATION 10/14/84	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY BYPASS SURGERY	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/19 , 19 84 , to 12/5/84 , 19 84 , that (I) (we) last saw the deceased alive on 12/5 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Anthony L. Moulton MD		22c. DATE SIGNED 12/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY L. MOULTON		22e. ADDRESS 22 S. GREEN ST., BALTIMORE, MD.	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE Dec. 12, 1984	23c. NAME OF CEMETERY OR CREMATORY Waters Memorial	23d. LOCATION CITY OR TOWN COUNTY Lusby Calvert Md

24. FUNERAL DIRECTOR NAME DONALD V. BORGWARDT	25a. DATE REC'D. BY REGISTRAR DEC 13 1984	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, or medical examination, or other event, must be reported to the medical examiner.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 7 5

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NOAH H BEYER			2a. DATE OF DEATH MONTH DAY YEAR 12 27 84		2b. HOUR 744 P.M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 18 1898		6. AGE (IN YEARS (LAST BIRTHDAY)) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED. CEN.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2611 FOSTER AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES BEYER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA ROBERTS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 21301 1576		17. INFORMANT ADDRESS MARIE PIASECKI 2611 FOSTER AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) ASPIRATION								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Multiple CVA's = absent gag reflex; Lamentation									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec 17, 1984 to Dec 27, 1984 , that (I) (we) last saw the deceased alive on Dec 27, 1984 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Michael Soulen				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL SOULEN				22e. ADDRESS FRANCIS SCOTT KEY MED CTR BALT MD 21209					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/31/1984		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.			
24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI				ADDRESS 2525 FLEET ST.		25a. DATE REC'D. BY REGISTRAR DEC 31 1984		25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 4 7 6

1. DECEASED NAME (TYPE OR PRINT) Barbara Biddison		2a. DATE OF DEATH MONTH DAY YEAR December 08, 1984		2b. HOUR 7:10p	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 8 06	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 78	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE MARYLAND		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12c. KIND OF BUSINESS OR INDUSTRY Homemaking	
13a. CITY OR TOWN BALTIMORE		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 21228 Caton Manor N. H. Balto., Md.	
14. FATHER'S NAME FIRST MIDDLE LAST Conrad Reich		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Frederick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 215-09-0116		17. INFORMANT ADDRESS Virginia M. Page 1204 Abinchar Dr. 21009	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomegely (heart weight 650 grams) DUE TO, OR AS A CONSEQUENCE OF (c) Moderate arteriolar nephrosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: History of Congestive Heart Failure, Urinary Tract Infection					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from November 23, 19 84 to December 8, 19 84 , that (we) last saw the deceased alive on December 8, 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (saw) view the body after death.					
22b. SIGNATURE P. Sandhu		DEGREE MD		22c. DATES SIGNED 12/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Parminderjeet Sandhu, M.D.		22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-11-84		23c. NAME OF CEMETERY OR CREMATORY Zion Luth.Ch.Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		25a. ADDRESS 7401 Belair Rd. BALTO. MD. 21234		25b. DATE REC'D. BY REGISTRAR DEC 13 1984	
25c. REGISTRAR'S SIGNATURE J. Davidson-Robert					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 7 7 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) IWA W. Billig					2a. DATE OF DEATH MONTH DAY YEAR 12 - 7 - 84			2b. HOUR 8:00 A			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 8 97		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
11. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Se. Baltimore Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland					13b. COUNTY A.A. Co.		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Wilson Small					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Davis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 165 20 4472		17. INFORMANT ADDRESS Balto. Md 21225 Olive E. Hornberger 103 Ninth Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min	
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure											
DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 11-26 , 19 84 , to 12-7 , 19 84 , that (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Felins			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12-7-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond J. Felins			22e. ADDRESS 3001 S. Hanover St. Baltimore Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/11/84		23c. NAME OF CEMETERY OR CREMATORY McIntyre Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Catawissa Columbia Co., Pa.			
24. FUNERAL DIRECTOR NAME George J. Gonce			BALTO. MD. 21225			25a. DATE REC'D. BY REGISTRAR DEC 11 1984			25b. REGISTRAR'S SIGNATURE Gelia Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 7 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MORRIS		MIDDLE		LAST BIRENBAUM		2a. DATE OF DEATH		MONTH DAY YEAR HOUR 12 21 54 106 AM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7 20 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF BALTIMORE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHAUFFEUR		12b. KIND OF BUSINESS OR INDUSTRY CAB			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN RANDALLSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3726 Springdale Ave 21133			
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS BIRENBAUM				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-03-4632		17. INFORMANT MRS. ROSE BIRENBAUM 3726 SPRINGDELL AVE., RANDALLSTOWN, MD 21133							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Anoxic Encephalopathy, Myocardial Ischemia											
19a. DATE OF OPERATION 12/11/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Superior Mesenteric Artery Thrombosis				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/11, 19 84, to 12/21, 19 84, that (I) (we) lost saw the deceased alive on 12/21, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Randal M. Sedlak M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/21/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Randal M. Sedlak				22e. ADDRESS Sinai Hospital of Baltimore							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 23, 1984		23c. NAME OF CEMETERY OR CREMATORY BETH YEHUDA ANSHE KURLAND		23d. LOCATION CITY OR TOWN BALTIMORE		23e. MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE Julia Levinson					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 4 7 9
REG. NO.

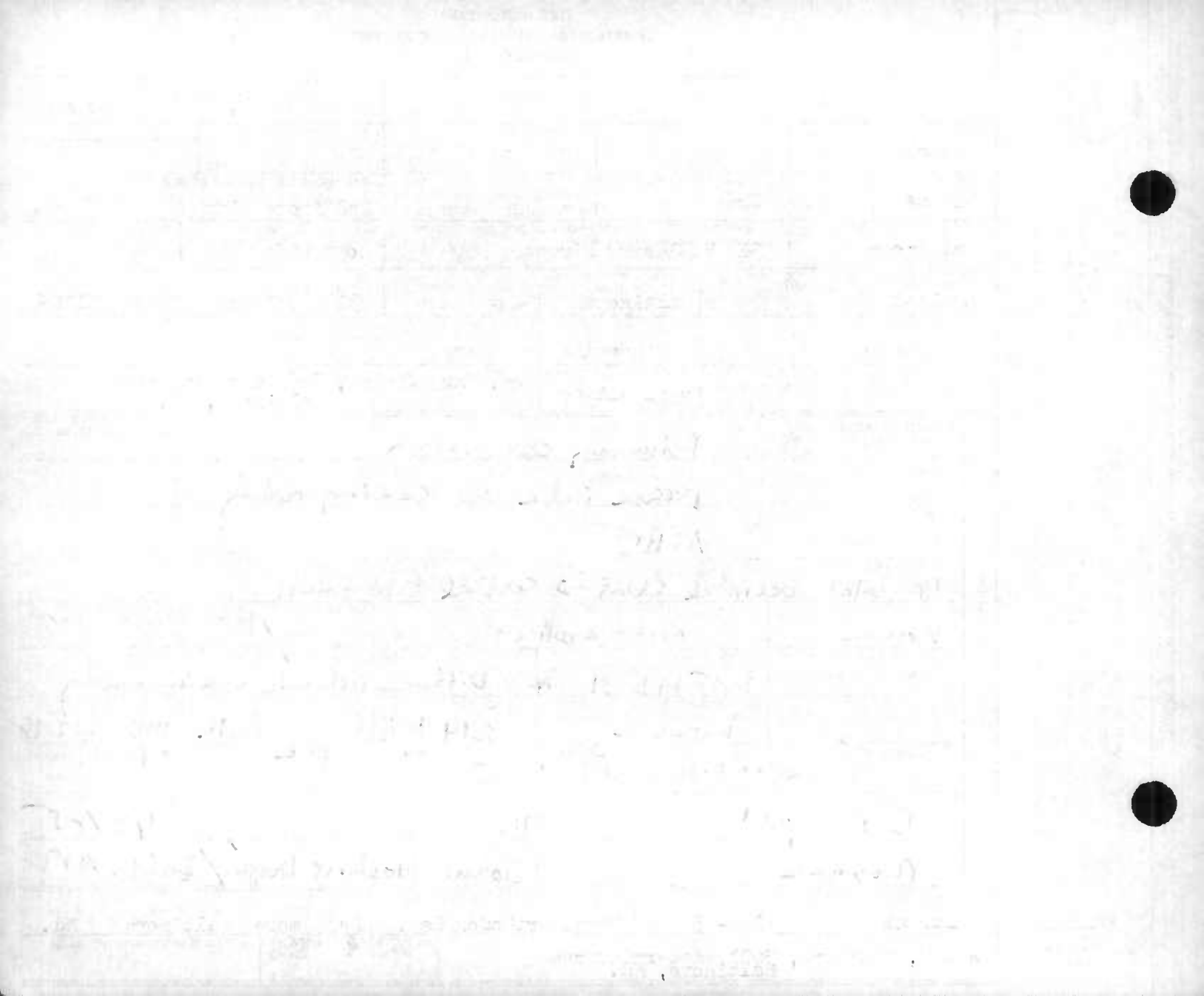
1. DECEASED NAME (TYPE OR PRINT) IRENE BISBIKIS		2a. DATE OF DEATH MONTH DAY YEAR December 31, 1984		2b. HOUR 2:00 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 25 99		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Greece	7b. CITIZEN OF WHAT COUNTRY? Greece	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) 3314 McElderry Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY -	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Gianoudis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 232-03-4387D		17. INFORMANT ADDRESS Mrs. Mary Xintas, 806 Rappolla Street Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse ischemic cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) slp bilat occipital CVA → cortical blindness					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED not applicable		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 P.M. 12 31 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Diffuse ischemic cardiomyopathy	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) None		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3314 McElderry Balt. MD 21218	
22a. I certify that (I) (this hospital) attended the deceased from July 19 84 , to Dec 19 84 , that (I) (we) lost saw the deceased alive about 12/12 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. Royall		DEGREE MD		22c. DATE SIGNED 1/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Royall		22e. ADDRESS Johns Hopkins Hosp. / Balt. MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-3-85		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.		23e. DATE RECEIVED BY REGISTRAR JAN 4 1985			
24. FUNERAL DIRECTOR NAME Ann S. Matthews, 3021 Eastern Avenue Baltimore, Md.		25. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 4 8 0

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		10:30 p	
EDWARD JOSEPH BISIGNANI		12 15 84			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	CAUCASIAN	9 - 6 - 1924	60	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
PA.	U.S.A.		BALTO. CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
BALTO.	VAMC BALTIMORE, MARYLAND 21218		Bricklayer	Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md			BALTO.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3515 CLAREMOUNT ST. 21224
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Joseph	Adela	Yes			
17. INFORMANT		18. SOCIAL SECURITY NO.			
Auretha Bisignani		198 14 2307			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:		21. CARDIOPULMONARY ARREST			
IMMEDIATE CAUSE (a)					
DUE TO, OR AS A CONSEQUENCE OF		22. SEPSIS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
21a. DATE OF OPERATION	21b. CONDITION FOR WHICH OPERATION WAS PERFORMED	21c. AUTOPSY?	21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
21h. INJURY OCCURRED	21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21j. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	22c. DATE SIGNED	22d. PHYSICIAN'S NAME (TYPE OR PRINT)			
M. Antos MD	12/17/84	M. Antos MD			
22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
L. R. VAH, BALTO MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
BURIAL	Dec 19, 1984	SACRED Ht. of Jesus	BALTO. COUNTY MD.		
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph N. ZANNINO JR.		DEC 20 1984		John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 8 1 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Preston M. Black						2a. DATE OF DEATH MONTH DAY YEAR December 22, 1984			2b. HOUR 9:49A M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 3 05		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 480 Cummings Ct. 21201			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Black						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-05-9171		17. INFORMANT ADDRESS Carrie Black 480 Cummings Ct.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction (Massive) DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 22, 1984 , to December 22, 1984 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 22, 1984 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.											
22b. SIGNATURE Gary W. Merritts M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/23/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary W. Merritts, M.D.						22e. ADDRESS c/o Maryland General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/26/84		23c. NAME OF CEMETERY OR CREMATORY Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fruitland MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H						1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Judith Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 8 2 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sophie (Sophia) BLACK					2a. DATE OF DEATH MONTH DAY YEAR 12 19 84				2b. HOUR 1:10 P.M.		
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 25 01		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GEN. HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 717 Druid Lake Dr. #501			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 250-05-4911		17. INFORMANT ADDRESS Elijah Black 717 Druid Lake Dr. #501					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>- LUNG TUMOUR -</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>12-19-84</u> to <u>12-19-84</u> , that (I) (we) lost the deceased alive on <u>12-19-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.											
22b. SIGNATURE <i>Sudhir D. Patel</i>					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12-19-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUDHIR D. PATEL					22e. ADDRESS NORTH CHARLES GEN. HOSP.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-24-84		23c. NAME OF CEMETERY OR CREMATORY Md. National			23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Md.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.					25a. DATE REC'D BY REGISTRAR DEC 20 1984						

NAME

100% COTTON



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 4 8 3
REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Robert

Leroy

Blacksten, Jr.

7a. DATE KNOWN OF DEATH
ESTIMATED ☒ MONTH DAY YEAR
12-15 1984

2b. HOUR
M

3. SEX
MALE

4. RACE
WHITE

5. DATE OF BIRTH
MONTH DAY YEAR
Sept 15 1935 49 YRS.

6. AGE (IN YEARS)
LAST BIRTHDAY
MONTHS DAYS HOURS MIN

7. IF UNDER 1 YR.
IF UNDER 24 HRS.
HOURS MIN

2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
12-15 1984

2d. HOUR
P. M.
11:24

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Route Salesman
12b. KIND OF BUSINESS OR INDUSTRY
Merchandising

13a. STATE
Md.

13b. CITY OR TOWN
Baltimore

13c. STREET ADDRESS
3003 Belair Rd. 21213

14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT L. BLACKSTEN SR.

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY E. CASSELL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yew

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Peacetime 213-34-0734

17. INFORMANT ADDRESS
Clara Blacksten (wife) same address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?
YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE

Dennis F. Smyth

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 12-17-84

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL

23b. DATE
12/19/84

NAME OF CEMETERY OR CREMATORY
Meadowridge Mem, Pk.

23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md.

24. FUNERAL HOME NAME
Schimunek Funeral Home, Inc.
ADDRESS
3331 Brehms Lane, Balto. Md. 21213

25a. DATE REC'D. BY REGISTRAR
DEC 18 1984

25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

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DHMH - 17
(VR A15 ME (5))



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 8 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HOWARD RANDOLPH BLACKWELL			2a. DATE OF DEATH MONTH DAY YEAR 12 30 84		2b. HOUR 2:25A M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Apr. 26, 33	6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, BALTIMORE, MD. 21218		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3423 Yatauba Dr. 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Hurby C. Blackwell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Dobyns			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-28-8345	17. INFORMANT ADDRESS Julia Blackwell 3423 Yatauba Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>metastatic colon cancer</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/21, 19 84, to 12/30, 19 84, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 12/30, 19 84, and that in item 2 (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. Schamy MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Schamy MD		22e. ADDRESS 3900 LOCH RAVEN BLVD. BALTO. MD. 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-4-85	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest	23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md.		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.		ADDRESS JAN 3 1985		REGISTERAR'S SIGNATURE D. Schamy	

BP

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English 101

101 English

101 English

101 English

File G599 item 16b
1- STATE REGISTRAR 1/11/85 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 8 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) BRADFORD E. BLAKE, SR.			2a. DATE OF DEATH MONTH DAY YEAR December 20, 1984			2b. HOUR 219 P M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 11, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6109 Maywood Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Agent		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 6109 Maywood Ave., 21209									
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Blake			15. MOTHER'S MAIDEN NAME MIDDLE LAST Emma Myer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW 1		17. INFORMANT ADDRESS Mrs. Mildred Blake, Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (he) (this hospital) attended the deceased from <u>10/31</u> 19 <u>84</u> to <u>12/20</u> 19 <u>84</u> , that (he) (we) lost saw the deceased alive on <u>10/31</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (s) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Eric Fisher</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Fisher, MD			22e. ADDRESS 1900 E. Northern Parkway, Balto., MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/22/84		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, MD		
24. FUNERAL DIRECTOR NAME 4905 York Road Balto., MD 21212			25a. DATE REC'D. BY REGISTRAR DEC 21 1984			25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

MEDICAL CERTIFICATION

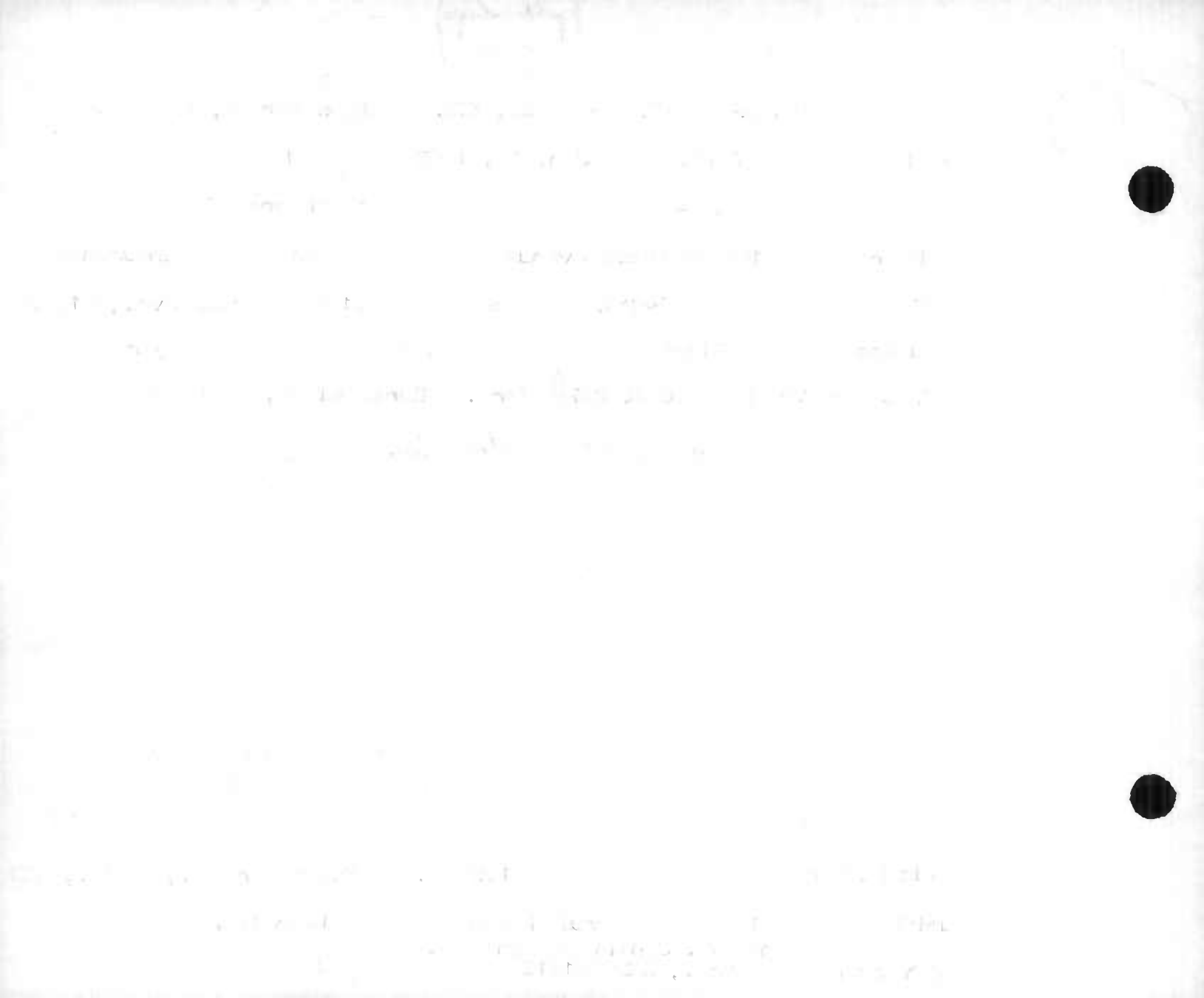
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 2 4 8 6

1. DECEASED NAME (TYPE OR PRINT)			FIRST Robert			MIDDLE Vinton			LAST Blake			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12-28 1984			2b. HOUR M 5:36 p. M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 14 15 69		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 69		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-28 1984			7d. HOUR M 5:36 p. M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6118 Bessemer Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY Steamfitter					
13a. STATE Maryland				13b. COUNTY -----				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 6118 Bessemer Avenue 21224			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Blake								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Lippy											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) W.W. 2 212-09-8026				17. INFORMANT ADDRESS Robert B. Blake 9482 Seven Courts Rd.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 12-30-84							
EXAMINER'S NAME (TYPE OR PRINT)				Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-31-84				23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith				23d. LOCATION (CITY OR TOWN) COUNTY STATE Overlea, Balto. Co., Md.							
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.				ADDRESS 901 S. Conkling St.				25a. DATE REC'D. BY REGISTRAR DEC 31 1984				25b. REGISTRAR'S SIGNATURE <i>Peter Davidson-Randall</i>							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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Keywords: child abuse; child sexual abuse; child sexual exploitation

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6/18 REMINDER: JUNE 21/24

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 8 7

1- FOR
STATE
REGISTRAR

REG. NO.

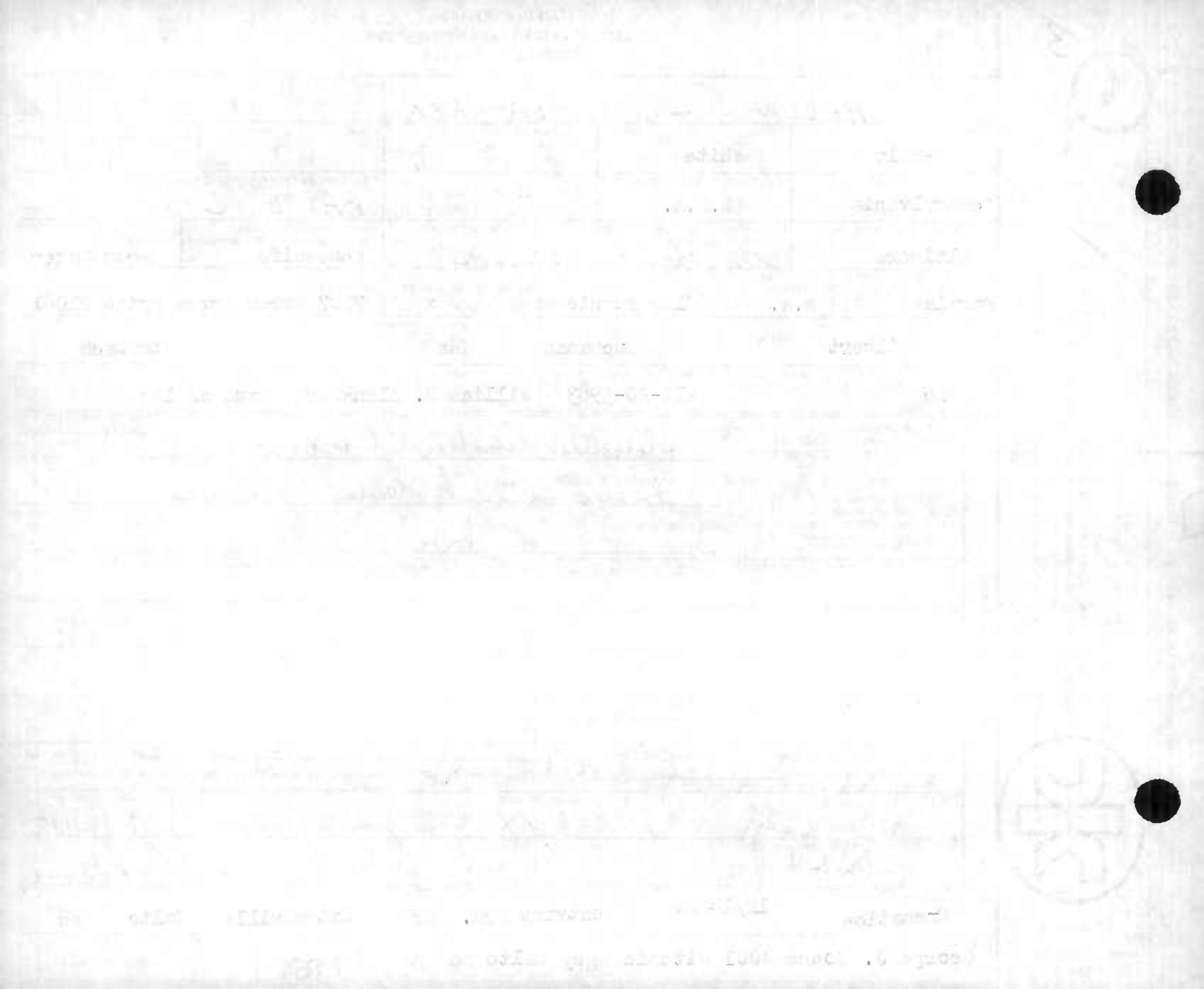
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN L. BLANKNER			2a. DATE OF DEATH MONTH DAY YEAR 12 12 84			2b. HOUR 9:25 P.M.	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 15 24		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. BALTO GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Home Maker		13a. STATE Maryland		13b. CITY OR TOWN A.A.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13d. STREET ADDRESS 7307 Green Acres Drive 21061		14. FATHER'S NAME FIRST MIDDLE LAST Wilbert Buchanan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Stombach			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-20-5983		17 INFORMANT ADDRESS William S. Blankner Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Epithelial Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epithelial bleeding, obstructed DUE TO, OR AS A CONSEQUENCE OF (c) 2° above							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/08 19 84 , to 12/12 19 84 , that (I) (we) last saw the deceased alive on 11/12 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE W. J. Gonce		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. GRAHVO		22e. ADDRESS 8651 Ft Smallwood Rd Pasadena					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/14/84		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hgwy Balto Md				25a. DATE REC'D. BY REGISTRAR DEC 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 4 8 8

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>James</i> <i>Blight</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 8 84</i>			2b. HOUR <i>8:30 A.M.</i>			
3. SEX <i>M</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 4 18</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>66</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore City</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Francis Scott Key Medical Ctr.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Observer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Sparrows Pt.</i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Elmer</i> <i>Blight</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary</i> <i>Belle</i> <i>Rambo</i>			16. ADDRESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW II</i>		17. INFORMANT <i>Margaret Blight</i>				
17a. ADDRESS			17b. ADDRESS <i>4603 Springwood Ave. 21206</i>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *respiratory arrest*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) *Brain tumor - probable Glioblastoma*

DUE TO, OR AS A CONSEQUENCE OF

(c) *ALS*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M.W. Hawke</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>12/8/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M.W. Hawke</i>				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-11-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Louise F.H. 7401 Belair Rd</i> ADDRESS <i>DEC 13 1984</i>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar. Page 3 should be filed in the office of the Registrar. Page 4 should be filed in the office of the Registrar. Page 5 should be filed in the office of the Registrar. Page 6 should be filed in the office of the Registrar. Page 7 should be filed in the office of the Registrar. Page 8 should be filed in the office of the Registrar. Page 9 should be filed in the office of the Registrar. Page 10 should be filed in the office of the Registrar. Page 11 should be filed in the office of the Registrar. Page 12 should be filed in the office of the Registrar. Page 13 should be filed in the office of the Registrar. Page 14 should be filed in the office of the Registrar. 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Page 100 should be filed in the office of the Registrar.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 4 8 9	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH ANN BLINCO					2a. DATE OF DEATH MONTH DAY YEAR 12-16-84					2b. HOUR 8⁰⁰ a.m.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 5 1931		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED. CEN.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b. KIND OF BUSINESS OR INDUSTRY SEAFOOD CO.			
13a. STATE MD.		13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 324 S. EAST AVE. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST STEPHEN BRZEZINSKI					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER JAMESON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 218-28-9474		17. INFORMANT ADDRESS ESTHER LURZ (MOTHER) 3434 CLIFTMONT AVE. 21213						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Intracerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension, s/p CVA 15 y's ago											
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) -					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> -			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -			21f. LOCATION STREET CITY OR TOWN COUNTY STATE -					
22a. I certify that (I) (this hospital) attended the deceased from 12/13 , 19 84 , to 12/16 , 19 84 , that (I) (we) last saw the deceased alive on 12/16 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eric C. Strain						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIC C. STRAIN						22e. ADDRESS 4940 Eastern Ave. Balto, MD 21224					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.			
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC.						25a. DATE REC'D. BY REGISTRAR DEC 18 1984		25b. REGISTRAR'S SIGNATURE Gina Davidson			
ADDRESS 3331 Brehms Lane Balto. Md. 21213											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 4 9 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MELVIN BLOCK				2a. DATE OF DEATH MONTH DAY YEAR 12 - 19 - 84		2b. HOUR MIN. 11:04 AM	
3. SEX M MALE	4. RACE W WHITE	5. DATE OF BIRTH MONTH DAY YEAR 02 - 18 - 18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MD	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE		13e. STREET ADDRESS 5804 RUBIN AVE 21215			
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS BLOCK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA KRAMER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 215 056983		17. INFORMANT MRS. SYLVIA BLOCK		5804 RUBIN AVE. #21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (c) ADENOCARCINOMA UNKNOWN PRIMARY PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-20-84 , 19____, to 12-19-84 , 19____, that (I) (we) last saw the deceased alive on 12-19-84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald R. Taylor MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. TAYLOR				22e. ADDRESS DEPT. MED. SINAI HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 20, 1984		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR DEC 28 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 4 9 1

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
WILLIE		BLUE		December 5, 1984		3:47P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male	Black	10 26 1917		67 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina	U.S.A.			BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	VAMC BALTIMORE MARYLAND		Bethlehem STEEL		STEEL 1		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
13a. STATE 13b. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21222			
Md. Balto.		Turners		231 Chestnut Street			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Richard E. Blue		Mary Mcmillian					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
yes		241 10 8164		Mrs. Edna Blue 231 Chestnut St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Cancer of Livers</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 4, 1984</u> to <u>December 5, 1984</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 5, 1984</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Jonathan Root MD</u>						12/6/84	
22d. PHYSICIAN'S HOME (TYPE OR PRINT)				22e. ADDRESS			
<u>Jonathan Root MD</u>				3900 Loch Raven Blvd. Baltimore MD 21218			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12/8/84		Arbutus		Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James A. Morton & Sons 1701 Laurens St.				DEC 10 1984		<u>John Davidson-Randall</u>	

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

[Faint, illegible handwritten text and markings covering the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

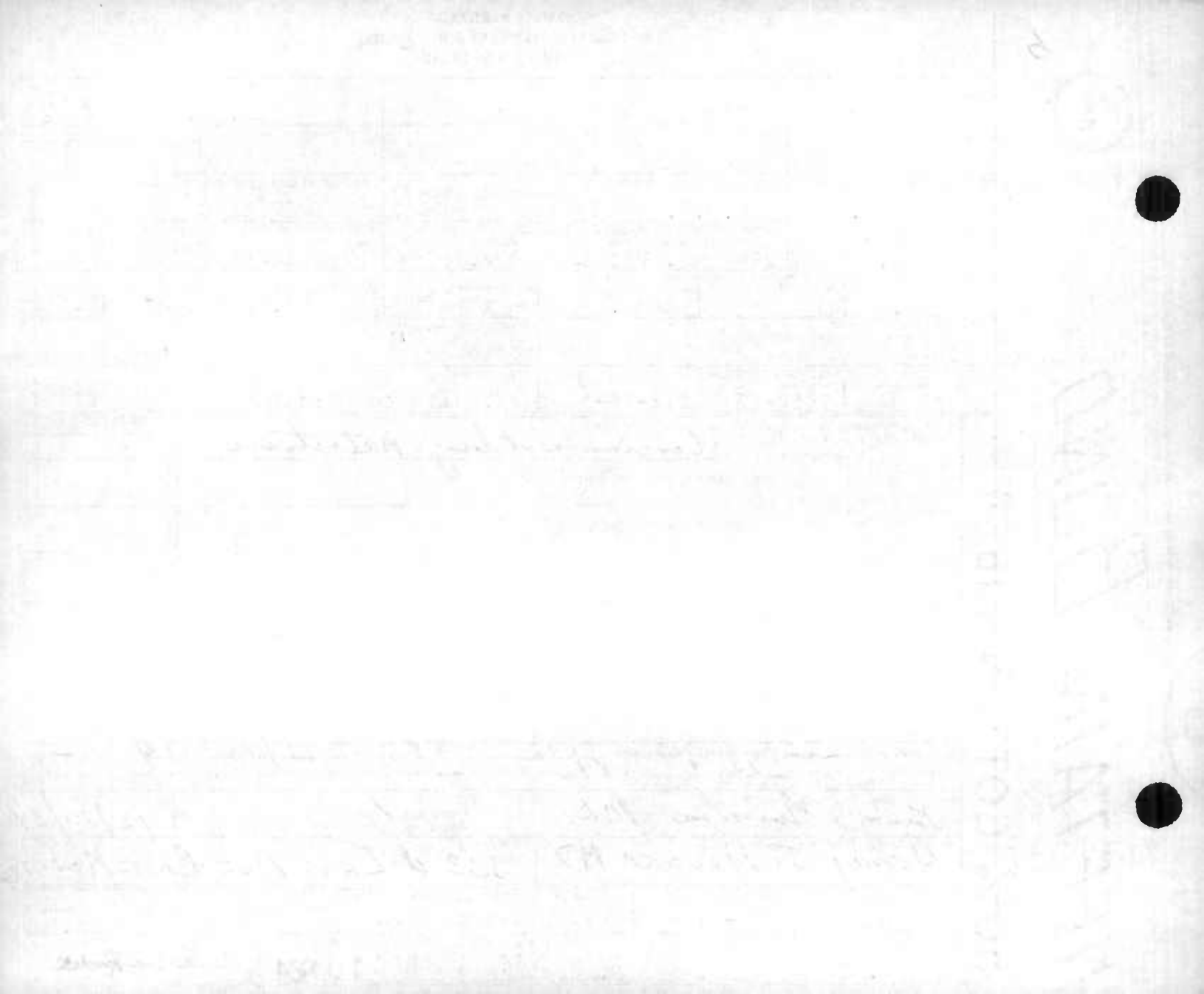
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 4 9 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Frederick Blume			2a. DATE OF DEATH MONTH DAY YEAR Dec. 10, 1984		2b. HOUR 1:15 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 9 - 14 - 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3904 Mt. Pleasant Ave. 21224		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipefitter	12b. KIND OF BUSINESS OR INDUSTRY Crown Seal & Cork	
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3904 Mt. Pleasant Ave. 21224
14. FATHER'S NAME FIRST MIDDLE LAST John Blume		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothea Vorrath			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1920-23		17. INFORMANT Mrs. Mildred Blume	
				ADDRESS 3904 Mt. Pleasant Ave. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung - metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/12 1983 to 12/10 1984, that (I) last saw the deceased alive on 12/8 1984, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Henry J. Houska MD		DEGREE		22c. DATE SIGNED 12/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry J. Houska MD		22e. ADDRESS 333 d East Ave BALTO MD 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12 - 13 - 84	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md.
24. FUNERAL DIRECTOR NAME Joseph N. Zannino Jr. 263 S. Conkling		ADDRESS 21224		25a. DATE REC'D. BY REGISTRAR DEC 10 1984	
25b. REGISTRAR'S SIGNATURE Eula Davidson-Randall					

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 4 9 3
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nicholas M. Boblooch			2a DATE OF DEATH MONTH DAY YEAR 12 12 84			2b HOUR M M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 07 1900		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3939 Roland Ave. 21211				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
12b KIND OF BUSINESS OR INDUSTRY							
13a STATE Maryland				13b COUNTY --		13c CITY OR TOWN Baltimore	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS / ZIP CODE 3939 Roland Ave. 21211			
14 FATHER'S NAME FIRST MIDDLE LAST Nochola -- Boblooch				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary -- Ferraraci			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DAIES) WW I 215-10-1837		17 INFORMANT ADDRESS Mrs. Mary Nolan 6115 Marglenn Ave. 21206			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Recurrent aspiration and pneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hrs</i> <i>yes</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Recurrent aspiration and pneumonia</i>							
19a DATE OF OPERATION --		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>9-10-84</i> to <i>12-12-84</i> , that (I) (we) lost <i>12-5-84</i> saw the deceased alive on <i>12-5-84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did and did not view the body after death.							
22b SIGNATURE <i>Philip H. Moore</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>12/13/84</i>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Philip H. Moore, M.D.		22e ADDRESS 3925 Beech Ave. 21211					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/15/84		23c NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24 FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. 3818 Roland Ave. 21211				25a DATE REC'D. BY REGISTRAR DEC 18 1984			
25b REGISTRAR'S SIGNATURE <i>John A. Seitz, Jr.</i>							

BP

1

NOV 22 1908

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

[illegible]

[illegible]

DEC 1 8 1908

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 4 9 4
REG NO

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANK G. BODE				2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 12 26 19 84				2b. HOUR 7:40 PM	
3. SEX Male	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR 10 18 15	6. AGE (IN YEARS) LAST BIRTHDAY 69 YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 12 26 19 84		7d. HOUR 7:40 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3904 3rd St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Md. Shipbuilding		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3904 3rd Street, 212305	
14. FATHER'S NAME FIRST MIDDLE LAST Herman Bode				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kunigunda Unkown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-09-6580		17. INFORMANT ADDRESS Cookeville Robert Bode Route 5 Box 308A Tenn.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Alcoholism
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 12-27-84

EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS **111 Penn St., Balto., Md. 21201**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md.	
24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville Md				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

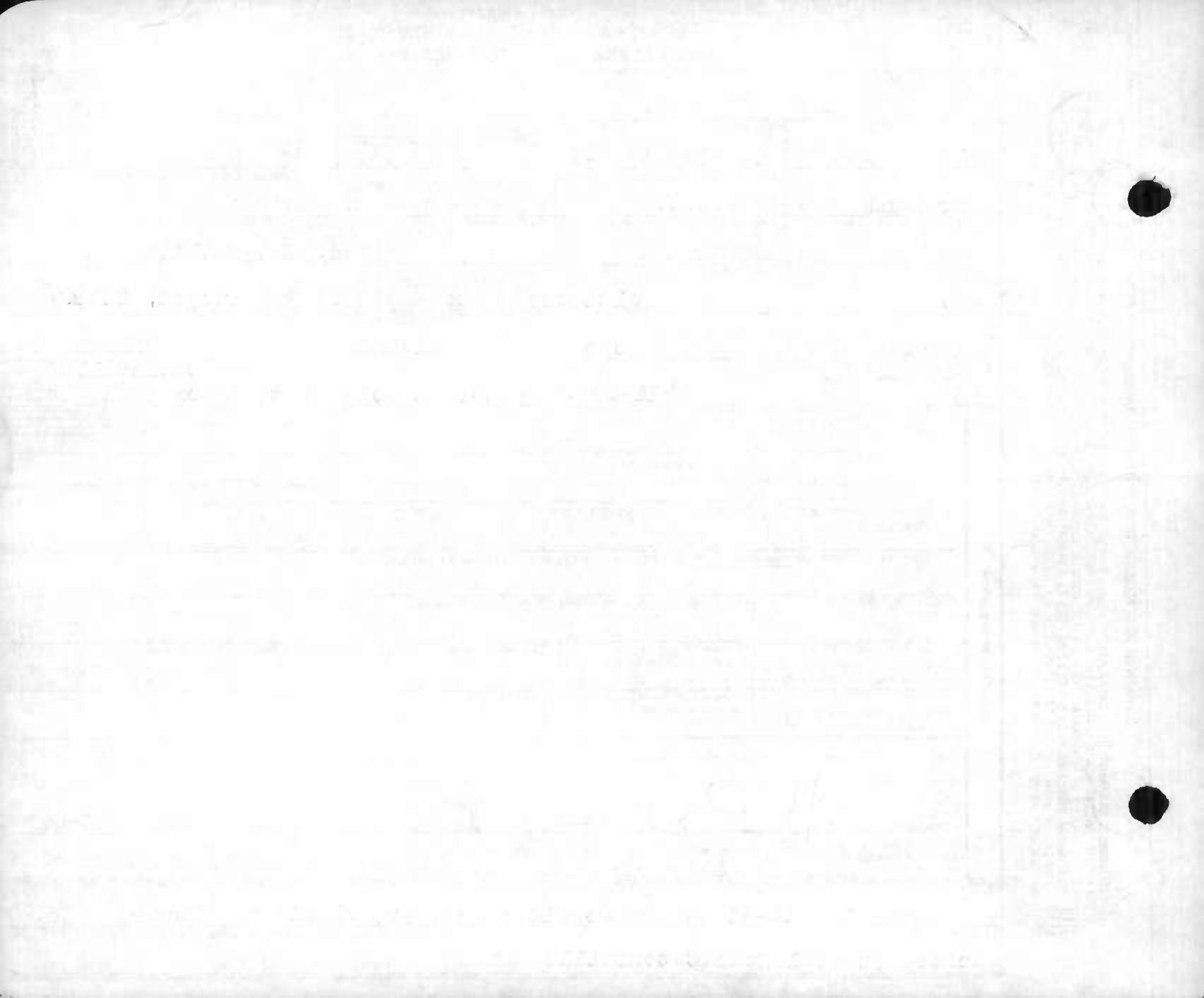
JAN 3 1985

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (1))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 4 9 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ALICE				2a. DATE OF DEATH MONTH 12 DAY 4 YEAR 89		2b. HOUR 225A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 6 DAY 10 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. <input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> UNDER 74 HRS. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med.Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Dundalk				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 108 Bayside Drive 21222	
14. FATHER'S NAME FIRST William MIDDLE DIXON LAST DIXON		15. MOTHER'S MAIDEN NAME FIRST Letitia MIDDLE Holdsworth LAST Holdsworth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234-96-4873		17. INFORMANT Naomi Peterson		ADDRESS Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 min
DUE TO, OR AS A CONSEQUENCE OF (b) ANTERIOR M.I.							36 HOURS
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 89 , to 12/4 , 19 89 , that (I) (we) last saw the deceased alive on 12/2 , 19 89 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John Duoss				DEGREE —		22c. DATE SIGNED 12/2/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Duoss MD				22e. ADDRESS Fisker Baltimore MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/7/1984		23c. NAME OF CEMETERY OR CREMATORY Beverly Hills Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Monongalia W.Va.	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222				25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE —	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 4 REG. NO. 32996	
1. DECEASED NAME (TYPE OR PRINT) <u>Catherine</u> <u>Bona parte</u>			2a. DATE OF DEATH 12/28/84		
3. SEX <u>F</u>	4. RACE <u>BLACK</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>5</u> / <u>28</u> / <u>12</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>VA.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Ba Ho. City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Ba Ho.</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>MERCY</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>
13a. STATE <u>Md.</u>	13b. COUNTY <u>Ba Ho</u>	13c. CITY OR TOWN <u>Ba Ho</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>813 Wildwood Pkwy</u> 21229	
14. FATHER'S NAME FIRST <u>SILAS</u> MIDDLE <u>JONES</u> LAST <u>JONES</u>		15. MOTHER'S MAIDEN NAME FIRST <u>MARY</u> MIDDLE <u>Cosby</u> LAST <u>Cosby</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT <u>Harnet Stoley</u> ADDRESS <u>813 Wildwood Pky</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Undifferentiated Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> , 19 <u>84</u> , to <u>12/28</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/28</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>12/28/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MOHAMMAD INAYAT</u>		22e. ADDRESS <u>Mercy Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	23b. DATE <u>1-3-85</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ba Ho NATI</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Ba Ho</u> <u>Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Joe. Martin</u> ADDRESS <u>1701 Lawrence St</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 31 1984</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



WINTER

20% OUTLINE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 300-1111.

FOR 1. STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		3 2 4 9 7 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Malinda BOOKER			2a. DATE OF DEATH MONTH DAY YEAR 12 8 84		2b. HOUR 8:40 AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 03 05		6. AGE (IN YEARS-LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNK - Retired		12b. KIND OF BUSINESS OR INDUSTRY —
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST George MIDDLE — LAST —		15. MOTHER'S MAIDEN NAME FIRST Drucillia MIDDLE — LAST Coley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) —	
16b. SOCIAL SECURITY NO. 220 30 5318		17. INFORMANT ADDRESS Frances Wright 4110 Alto Rd 21216			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
DUE TO, OR AS A CONSEQUENCE OF (b) Lactic Acidosis / Hepatic Failure					2-3 wks
DUE TO, OR AS A CONSEQUENCE OF (c) Hepatic Metastatic Cancer / Primary Colon Ca					Dx 1984
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/24 19 84 , to 12/8 19 84 , that (I) (we) last saw the deceased alive on 12/8 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bruce S. Gillies		DEGREE MD		22c. DATE SIGNED 12/8/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE S. GILLIES		22e. ADDRESS SINAI HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-11-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		24. FUNERAL DIRECTOR NAME Vernon R. Bailey ADDRESS 1348 N. Calhoun St.			
25a. DATE REC'D BY REGISTRAR DEC 12 1984		25b. REGISTRAR'S SIGNATURE John A. [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		3 2 4 9 8 REG. NO.		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEROY BOSIER		2a. DATE OF DEATH MONTH DAY YEAR 12/28/84		2b. HOUR 4:45AM	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 9 23 14		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Adelphi	
14. FATHER'S NAME FIRST MIDDLE LAST Moses Bosier		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucinda Canty		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 720-12-1462		17. INFORMANT ADDRESS Clara Clayton 21 E. 4th St. Mt. Vernon, NY 10550	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) INTRACEREBRAL INFARCT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a DECUBITUS ULCERS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 10/22/84 to 12/28/84, that (I) (we) lost saw the deceased alive on 12/28/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A.C. Chouvalit, M.D.				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/28/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A-C. CHOUVALIT, M.D.				22e. ADDRESS NORTH CHARLES GEN. HOSP.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/84		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD			
24. FUNERAL DIRECTOR NAME W.C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 31 1984		25b. REGISTRAR'S SIGNATURE Gina Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 3 2 4 9 9	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
			PETER C. BOSLEY		MONTH DAY YEAR 12 123 84	
3. SEX M			4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7/28/17	
6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7b. HOUR 12:20 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	
13a. STATE MD			13b. COUNTY BALTO		12b. KIND OF BUSINESS OR INDUSTRY	
13c. CITY OR TOWN ESSEX			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 900 MIDDLESEX RD.	
4. FATHER'S NAME FIRST MIDDLE LAST GRACEN BOSLEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IVY TAYLOR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWW II 218 073440		17. INFORMANT ADDRESS EDITH BOSLEY ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>long acting drug</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic cancer, History of 4 previous MI's, COPD</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION						
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/30, 1984, to 12/23, 1984, that (I) (we) lost saw the deceased alive on 12/23, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Mark N. Strommen			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK STROMMEN			22e. ADDRESS UNION Memorial Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/26/84		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD			23e. DATE REC'D. BY REGISTRAR DEC 28 1984			
24. FUNERAL DIRECTOR NAME ADDRESS J.G. CONNELLY 300 MACE			25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1- STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Boris Louis Boulmetis			2a. DATE OF DEATH MONTH DAY YEAR 12 10 84			2b. HOUR 2:50 PM			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 4 1900		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7 UNDER 1 YEAR MO. DAYS HOURS MIN. 12 10 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Andros, Greece		7b. CITIZEN OF WHAT COUNTRY? Baltimore		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Hat.		12b. KIND OF BUSINESS OR INDUSTRY Self	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5022 Balto. Nat. Pike Balto., Md. 21229	
14 FATHER'S NAME FIRST MIDDLE LAST Stamatis Boulmetis			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Andiana Boulmetis			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No			
16b. SOCIAL SECURITY NO. Sevastia Boulmetis			17. INFORMANT Wife			ADDRESS Balto., Md. 21229 5022 Balto. Nat. Pike			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) ASOB - COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/13 19 79 , to 12/10 19 84 , that (I) (we) lost saw the deceased alive on 5/13 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE John Shaw, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 5800 Franklin Ave. Baltimore, Md. 21206						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-13-84		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR G. Treman Schwab			25a. DATE REC'D. BY REGISTRAR DEC 12 1984			25b. REGISTRAR'S SIGNATURE John Davidson-Randell			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 977-4035.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 5 0 1			
FOR 1. STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Hattie M. Bowen					2a. DATE OF DEATH 12 05 84		2b. HOUR 22:00 AM						
3. SEX Female		4. RACE Black		5. DATE OF BIRTH 4-03-01		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY Pvt. Family					
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1600 W Mt. Royal Ave					
14. FATHER'S NAME FIRST MIDDLE LAST Clark Thompson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Gates								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.					16b. SOCIAL SECURITY NO. 215-22-9116		17. INFORMANT Sister Cecelia Marie					ADDRESS 3875 Lilli Bridge Detroit, Mich. 48214	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cause Resp. Arrest.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> 19 <u>84</u> to <u>12.05.84</u> 19 <u>84</u> that (I) (we) lost saw the deceased alive on <u>12.05</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>B. Nolan, M.D.</u>					DEGREE M.D.					22c. DATE SIGNED 12-05-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Nolan, M.D.					22e. ADDRESS Good Samaritan Hosp								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 12/10/1984		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR Nutter & Sons Funeral Home Inc.					25a. DATE REC'D. BY REGISTRAR DEC 12 1984			25b. REGISTRAR'S SIGNATURE <u>Celia F. ...</u>					



[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, or medical condition, the physician should attach a separate report.)

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES L. BOWLER, Sr.			2a. DATE OF DEATH MONTH DAY YEAR Dec 18th 84			2b. HOUR 7¹¹ PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 8 1923		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 7 11 00 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med.Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY Esskay	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 917 S. Marlyn Ave. 21221		
14. FATHER'S NAME (FIRST MIDDLE LAST) Lange C. Bowler			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Clara A. Bishop						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II			16b. SOCIAL SECURITY NO. 213-20-6499		17. INFORMANT ADDRESS Concetta C. Bowler Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) recent myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) left anterior coronary artery occlusion								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 1984 to 12/19/84 , that (I) (last) saw the deceased alive on 10/3 19 84 , and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (last) (did not) view the body after death.									
22b. SIGNATURE Dr. Disha Chandra			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec 20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DISHA CHANDRA, MD			22e. ADDRESS FRANCIS SCOTT KEY MEDICAL CENTRE; EASTERN AVE; BALTO. 21224						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/22/84		23c. NAME OF CEMETERY OR CREMATORY Sacred Ht. Of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Maryland		
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222						25a. DATE REC'D. BY REGISTRAR DEC 24 1984		25b. REGISTRAR'S SIGNATURE Gubia Davidson-Randall	

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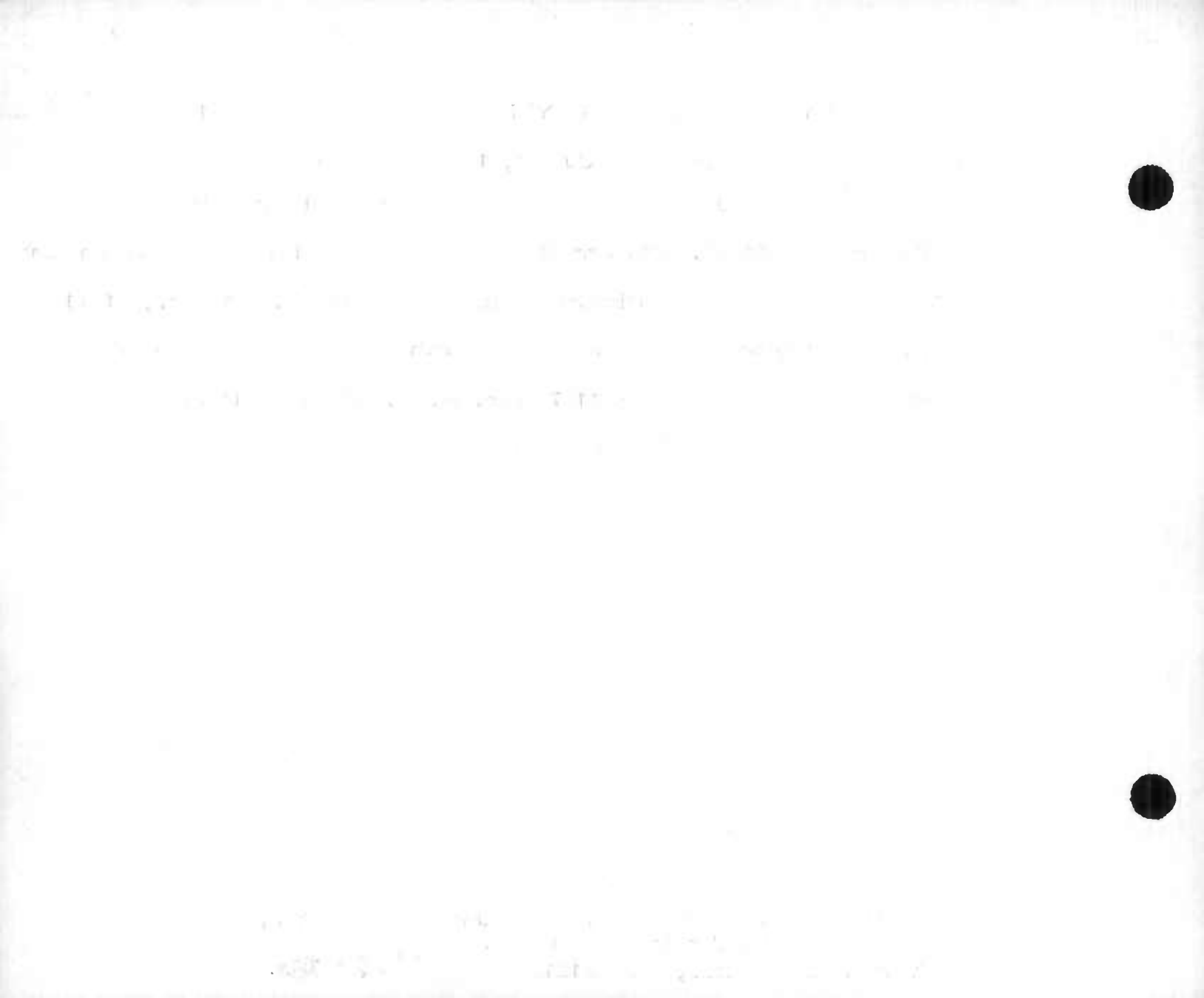
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE - 3 2 5 0 3 CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Edith G. BOYER					2a. DATE OF DEATH MONTH DAY YEAR December 21 1984			2b. HOUR 6:15 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 4, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 830 W. 40th Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office		12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 830 W. 40th St., 21211	
14. FATHER'S NAME FIRST MIDDLE LAST D. Taylor Boyer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Walker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 528 58 1107		17. INFORMANT ADDRESS Mr. R. B. Stoll, Balto., MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Three days</u> <u>~5 years</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from ~ 19 82 to Dec. 21 19 84, that (1) (we) lost saw the deceased alive on Dec. 21 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE <u>David D. Collins MD</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David D. Collins MD					22e. ADDRESS 500 W. University Pkwy. BALTO, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/24/84		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., MD			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212						25a. DATE REC'D. BY REGISTRAR DEC 26 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 5 0 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT U BRADFORD				2a. DATE OF DEATH MONTH DAY YEAR 12/27/84		2b. HOUR 7:10 PM	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 06 25 23		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 61	
7a. BIRTHPLACE (STATE AND COUNTRY) BALTIMORE MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMAN		12b. KIND OF BUSINESS OR INDUSTRY HAIRING	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2000 ODELL AVE 21237	
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT U. BRADFORD SR				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE BEAR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-14-8389		17. INFORMANT ADDRESS 5 WILKESY LANE 4126 NORFOLK			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ANURIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ANASARCA.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR DEC 27 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from DEC 27 19 84 to DEC 27 19 84 that (1) (we) lost saw the deceased alive on DEC 27 19 84 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) did not view the body after death.							
22b. SIGNATURE Mitchell Cohen		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MITCHELL COHEN MD		22e. ADDRESS 4940 EASTERN AVE BALTIMORE MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/31/84		23c. NAME OF CEMETERY OR CREMATORY Mt RUSHAN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR Wm A. Schuler 4387 9/11/84				25a. DATE REC'D. BY REGISTRAR DEC 31 1984			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

32505

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BESSIE BRADLEY		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 29, 1984		2b. HOUR P 10:30 AM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7-11-1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brunswick VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1022 McDonald St. 21205	
14. FATHER'S NAME FIRST MIDDLE LAST William - Parkman DeLia Feggam		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia - Feggam			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-14-7912		17. INFORMANT ADDRESS Dorothy Rice 4407 Springdale Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 H
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ALCOHOLISM, HYPERTENSION, GOUT					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/29 , 19 84 , to 12/29 , 19 84 , that (I) (we) last saw the deceased alive on 12/29/84 , 19 — , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Patrice A. Toye, M.D.		DEGREE M.D.		22c. DATE SIGNED 12/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICE A. TOYE, M.D.		22e. ADDRESS 600 N. WOLFE ST. BALTO. MD. JOHNS HOPKINS HOSPITAL, BALTIMORE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-4-85		23c. NAME OF CEMETERY OR CREMATORY Eastview	
23d. LOCATION Balto.		COUNTY City		STATE	
24. FUNERAL DIRECTOR NAME Geo. O. Smith F.H. 4600 Liberty Heights		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 4 1985	
25b. REGISTRAR'S SIGNATURE Richardson					

RELEASED AS NON - MED DR. DENNIS SMYTH PER MR. RICHARDSON

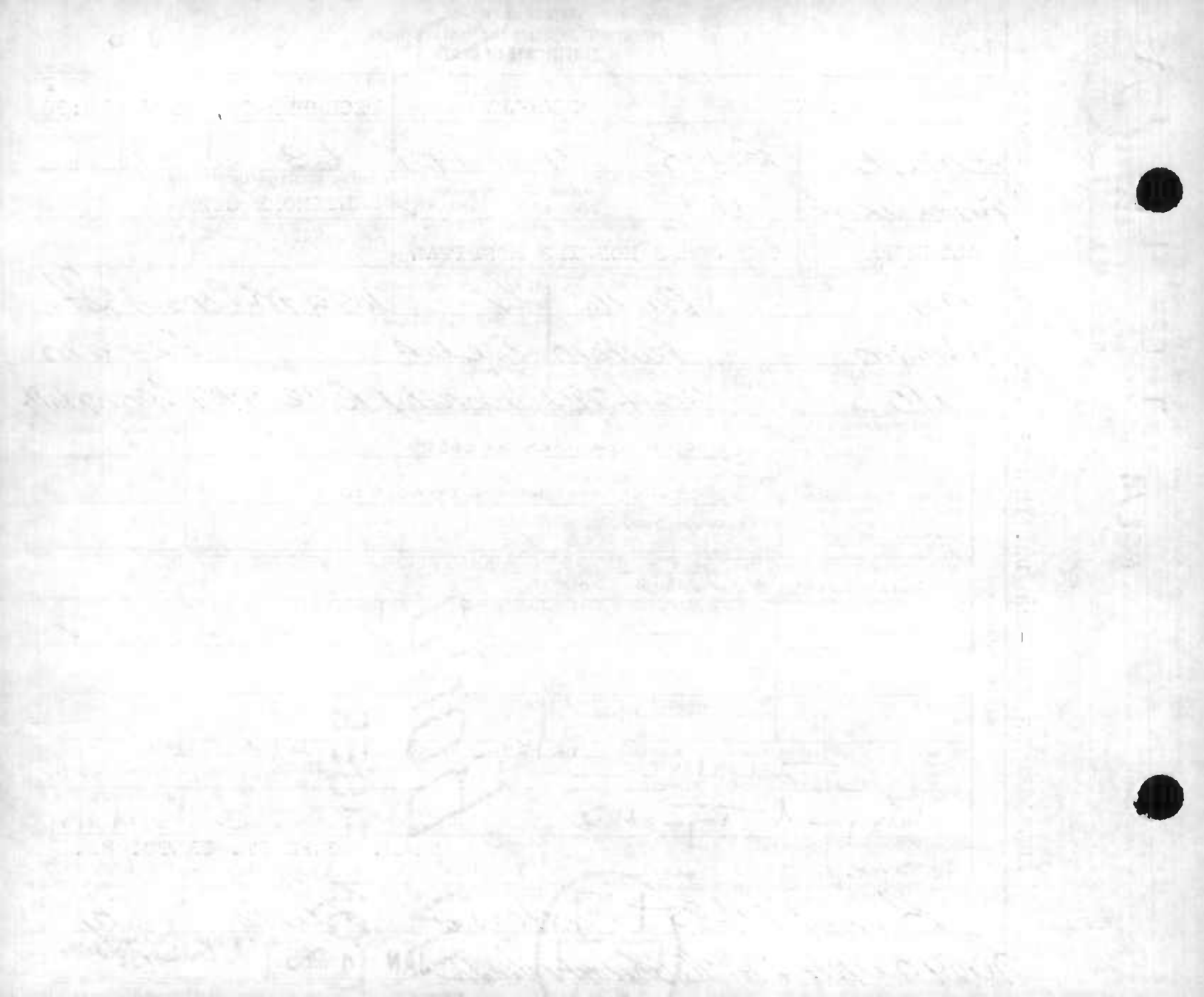
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										32506	
FOR 1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Lt. Col. William Maurice Brady					2a. DATE OF DEATH MONTH DAY YEAR 12 7 1984			2b. HOUR M M			
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 30 1897		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1805 N. Bentalou Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Veterans Administration			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST William T. Brady					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Cosley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17 INFORMANT Marie N. Brady		1805 N. Bentalou Street St. Baltimore, Maryland 21216					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cholecystitis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic renal insufficiency</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain Prostate hypertrophy</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia / Ventricular arrhythmia</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19</u> , 19 <u>78</u> , to <u>Dec. 7</u> , 19 <u>1984</u> , that (I) (we) last saw the deceased alive on <u>Dec. 7</u> , 19 <u>1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>					DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-18-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Brown, Anasnap</u>					22e. ADDRESS <u>844 N. Carey, Suite 2121</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/12/1984		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR'S NAME Nutter & Sons					25a. DATE REC'D. BY REGISTRAR DEC 19 1984			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
25c. ADDRESS 2501 Gwynns Falls Parkway Inc. Balto. Md. 21216											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 32507

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
Amy Georgia Breckenridge		12 16 84		6:23 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	8. IF UNDER 24 HRS
Female	Black	MONTH DAY YEAR	92 YRS.	MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U. S. A.		Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore City		Provident Hospital		Domestic	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		4206 Penhurst Avenue Baltimore, Maryland 21215	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Martin Whiten		Amy Johnson		No.	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c)	
215-32-1327		Eleanor Queen		Venricular fibrillation	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
R. Lopez				12/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
R. Lopez		2600 Liberty Wks Ave Baltimore		Burial	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
12/21/1984		Baltimore National Cem.		CITY OR TOWN COUNTY STATE	
24. NUTTER & SONS		2501 Gwynns Falls Parkway		25a. DATE REC'D. BY REGISTRAR	
Funeral Home Inc. Baltimore, Maryland 21216				DEC 19 1984	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
				John Davidson-McDell	

George Washington
May 1, 1892

U. S. A.

President Roosevelt

Washington

Dear Sir

715-22-1237 Eleanor Queen Baltimore, Maryland

Enclosed find
check for \$100.00

Yours truly

W. J. [illegible]
Baltimore, Maryland

General [illegible]
Baltimore, Maryland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 0 8

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) IRVIN W. BREMER			2a. DATE OF DEATH MONTH DAY YEAR 12-20-84 20 84 9 01 PM		
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 9-21-1927	6. AGE (IN YEARS LAST BIRTHDAY) 57 yrs.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY none
13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Irvin Bremer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Baldwin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1946	17. INFORMANT ADDRESS Lansdowne, Md. 21227 Doris Thomas 3105 Freeway		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular tachycardia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

minutes

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Cardiomyopathy of unknown etiology

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/6/84</u> , 19 <u>84</u> , to <u>12/20</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>W Kent Davis</u>	DEGREE	22c. DATE SIGNED <u>12/20/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W KENT DAVIS</u>	22e. ADDRESS <u>201 E. University Blvd</u>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-24-84	23c. NAME OF CEMETERY OR CREMATORY Highview Mem. Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.
24. FUNERAL HOME NAME ADDRESS Schironek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213		25a. DATE REC'D. BY REGISTRAR DEC 28 1984	25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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RECEIVED

DEPARTMENT OF AGRICULTURE

RECEIVED

11/25/14

X

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 5 0 9

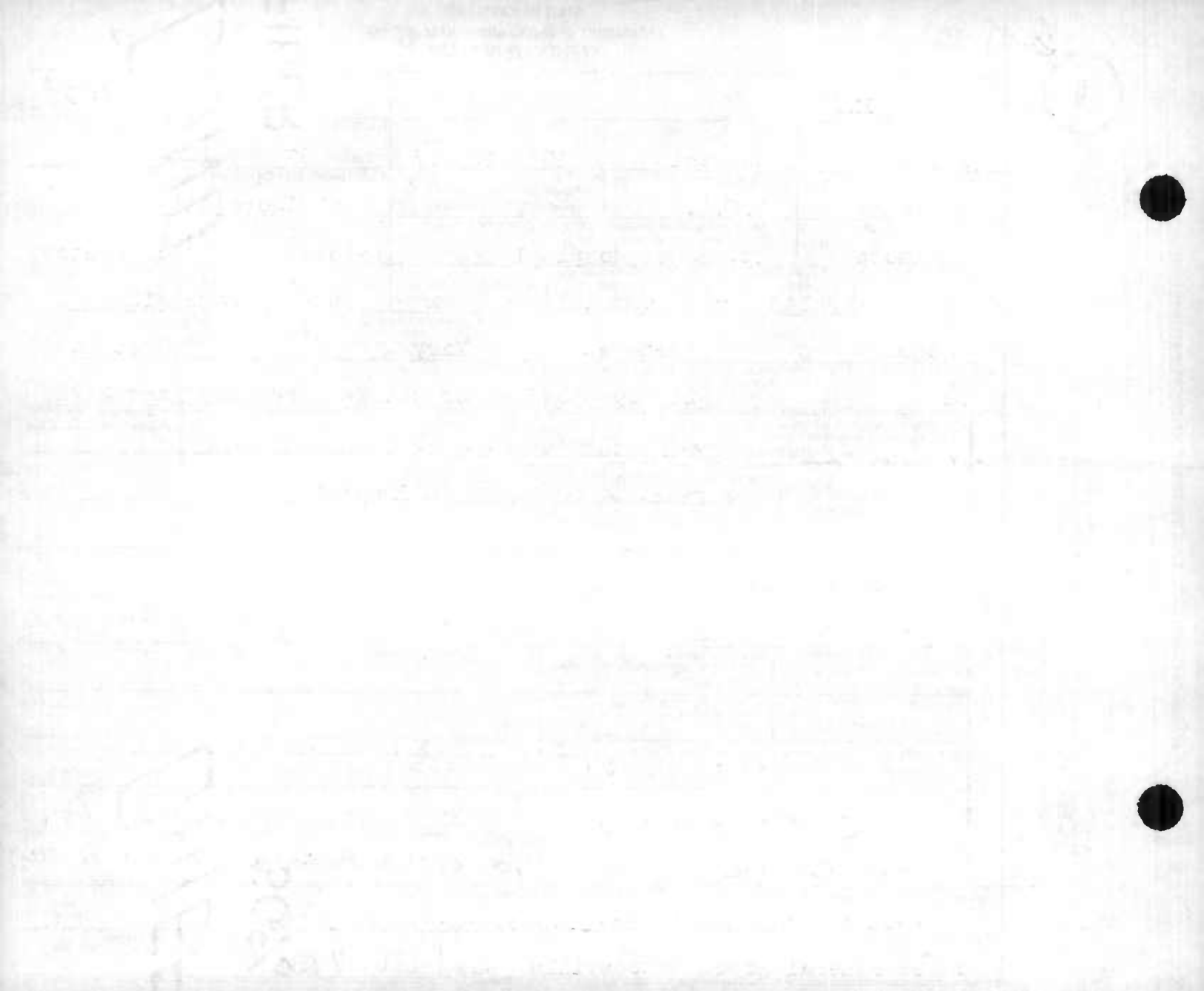
1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) IRENE BRENNEMAN			2a. DATE OF DEATH MONTH DAY YEAR 12 07 84			2b. HOUR 4:03 A M			
3. SEX Female		4. RACE Caucasin		5. DATE OF BIRTH MONTH DAY YEAR 10 16 97		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Box Factory	
13a. STATE Md.			13b. COUNTY Balto		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John C Breneman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Greenland			13e. STREET ADDRESS / ZIP CODE 8 Nunnery Lane 21228			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-09-5509		17. INFORMANT ADDRESS Eleanor Clarke 4 Nunnery Lane 21228					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia with sepsis DUE TO, OR AS A CONSEQUENCE OF (c) ovarian carcinoma									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 11/28/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small bowel obstruction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/27 19 84 , to 12/7 19 84 , that (I) (we) last saw the deceased alive on 12/7 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eve Bruce				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eve Bruce				22e. ADDRESS 900 CATON AVENUE, BALTIMORE 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-10-84		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md.			
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home				ADDRESS Catonsville Md		25a. DATE REC'D. BY REGISTRAR DEC 7 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP _____

DHMM - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32510				
1. DECEASED NAME (TYPE OR PRINT) JOHN J. BRENNAN				2a. DATE OF DEATH 12 01 84				2b. HOUR 3:02A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 18, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 74 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk - State			12b. KIND OF BUSINESS OR INDUSTRY Government			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4211 Granada Ave., 21215		
14. FATHER'S NAME FIRST MIDDLE LAST John T. Brennan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Kilroy								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW II 217 09 1064		17. INFORMANT Margaret E. Brennan,			ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARDS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PRESUMED SEPTIS</u> DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HYPOTHERMIA, RENAL FAILURE</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (a) this hospital attended the deceased from <u>11/17</u> , 19 <u>84</u> , to <u>12/1</u> , 19 <u>84</u> , that (1) <u>we</u> lost <u>the deceased</u> on <u>12/1</u> , 19 <u>84</u> , and that in (my) <u>mutual</u> opinion death occurred on the date and hour and from the causes stated above. (If not, please state did not view the body after death.)												
22a. SIGNATURE <u>Seth I. Weber</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/01/84			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) SETH I. WEBER						22e. ADDRESS C/O SINAI HOSPITAL, BALTIMORE MD 21215						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/4/84		23c. NAME OF CEMETERY OR CREMATORY St. Mary's			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212						25a. DATE REC'D. BY REGISTRAR DEC 4 1984						
25b. REGISTRAR'S SIGNATURE <u>Jane Davidson-Randall</u>												

12. 11. 61 3

J. EENNAN

MD

USA

Clark & State

4211 Grand Ave., 2121

MD

Baltimore

x

John

T.

Brannen

Wendy

A.

Kilroy

Yes

WW II

217 GE 104

Market E. S. Brannen

Barro

Clark

Wendy 4422

Wendy 4422

Wendy 4422

x

Barro

St. Mary's

10448A

Barro

Henry W. Brannen & Son Co.

1002 York Road, Baltimore, MD 21212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 5 1 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FAY			FIRST MIDDLE LAST BRESSLER			2a. DATE OF DEATH MONTH DAY YEAR 12 / 21 / 84			2b. HOUR 4:45 P.M.		
3. SEX FEMALE			4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 23, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. CHARLES GEN. HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS APT. 2C 6984 MILBROOK PARK DR. 21215		
14. FATHER'S NAME FIRST MIDDLE LAST HYMAN SCHUMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH OPPAS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-76-8438		17. INFORMANT SOL BRESSLER ADDRESS APT. 2C 6984 MILBROOK PARK DR. BALTO., MD 21215						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MI DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEVERE 3 vessel CAD DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 11/28, 1984 to 12/21, 1984 , that (I) (we) last saw the deceased alive on 12/21, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen H. Block DEGREE MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/21/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN H. BLOCK						22e. ADDRESS HEBREW YOUNG MEN					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 24, 1984		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR DEC 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP



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CHILLY



20% COTTON FIB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					3 2 5 1 2	
1- STATE REGISTRAR			REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Martenho (Mike) Britto			2a DATE OF DEATH MONTH DAY YEAR 12-29-84		2b HOUR 8 16 AM	
3 SEX M	4 RACE B	5 DATE OF BIRTH MONTH DAY YEAR 09-20-05	6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Portugal	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.			
10 CITY OR TOWN OF DEATH Balto	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a STATE Md.	13b COUNTY	13c CITY OR TOWN Balto.	13d STREET ADDRESS / ZIP CODE 611 S. Charles St. 21201			
14 FATHER'S NAME FIRST MIDDLE LAST ? ? ?		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 579-09-6994		17 INFORMANT ADDRESS Classie Britto 1361 Ward St. 21230		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) History of CVA DUE TO, OR AS A CONSEQUENCE OF (c) 1 1/2 hrs.						APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/29/84 to 12/29/84 , that (I) (we) last saw the deceased alive on 12/29/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE K. Robie Suh				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-29-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Robie - Suh				22e. ADDRESS Univ. of Md. Hosp.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-5-85		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Westport Md.
24. FUNERAL DIRECTOR NAME ADDRESS Chas. A. Rice FSPA 1300 Eutaw Place				25a. DATE REC'D. BY REGISTRAR IAN 4 1985		
				25b. REGISTRAR'S SIGNATURE Lelia T. ...		

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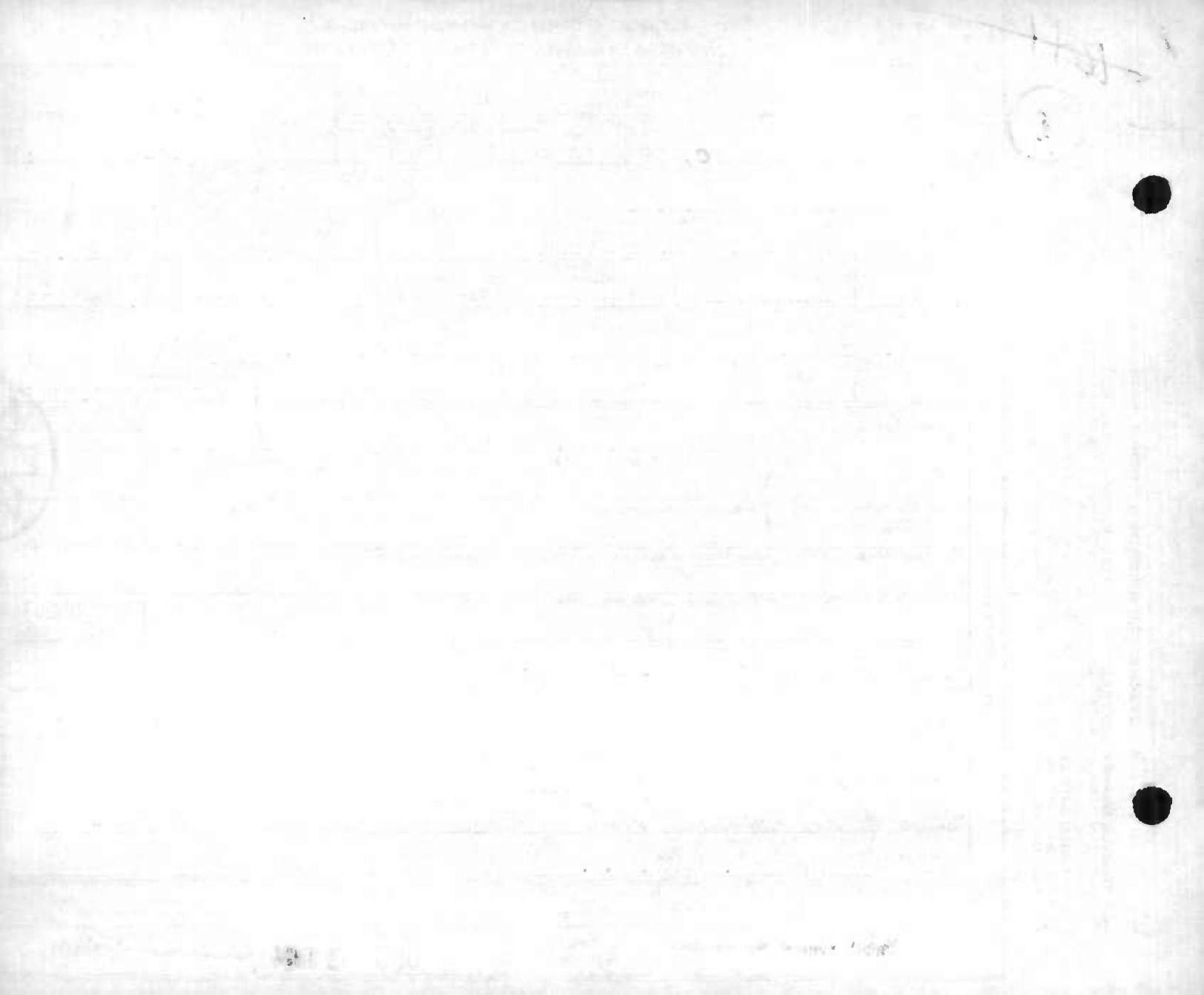
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 5 1 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a. DATE KNOWN OF DEATH			MONTH DAY YEAR			7b. HOUR					
JOSEPH EDWARD BROCATO						12-1-84			19			M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR			
Male		White		Mar 20, 1930		54 YRS.						12-1-84		19			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Arkansas				U.S.A.								Baltimore City					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore				3219 Woodring Avenue				Inspector				Can Co.,					
13a. STATE												13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Maryland												Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3219 Woodring Ave. 21234	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
John B. Brocato						Mary C. St. Columbia											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT					
Yes						213 28 0670						ANTHONY BROCATO BALTIMORE MD. 21236					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>																	
(c) <u></u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
						(HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
						? ?-?-84						self/inflicted					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION					
						home						3219 Woodring Avenue Baltimore, Maryland					
22a. I certify that I took charge of the remains delivered to me, and in my opinion death resulted from																	
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED					
<i>Thomas D. Smith</i>						M.D. Deputy Chief						12-2-84					
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS											
Thomas D. Smith, M.D.						111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL						11/5/1984		GARDENS OF FAITH				BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR				REGISTRAR'S SIGNATURE							
NAME						7110 Belair Road Baltimore, Md.				DEC 3 1984							

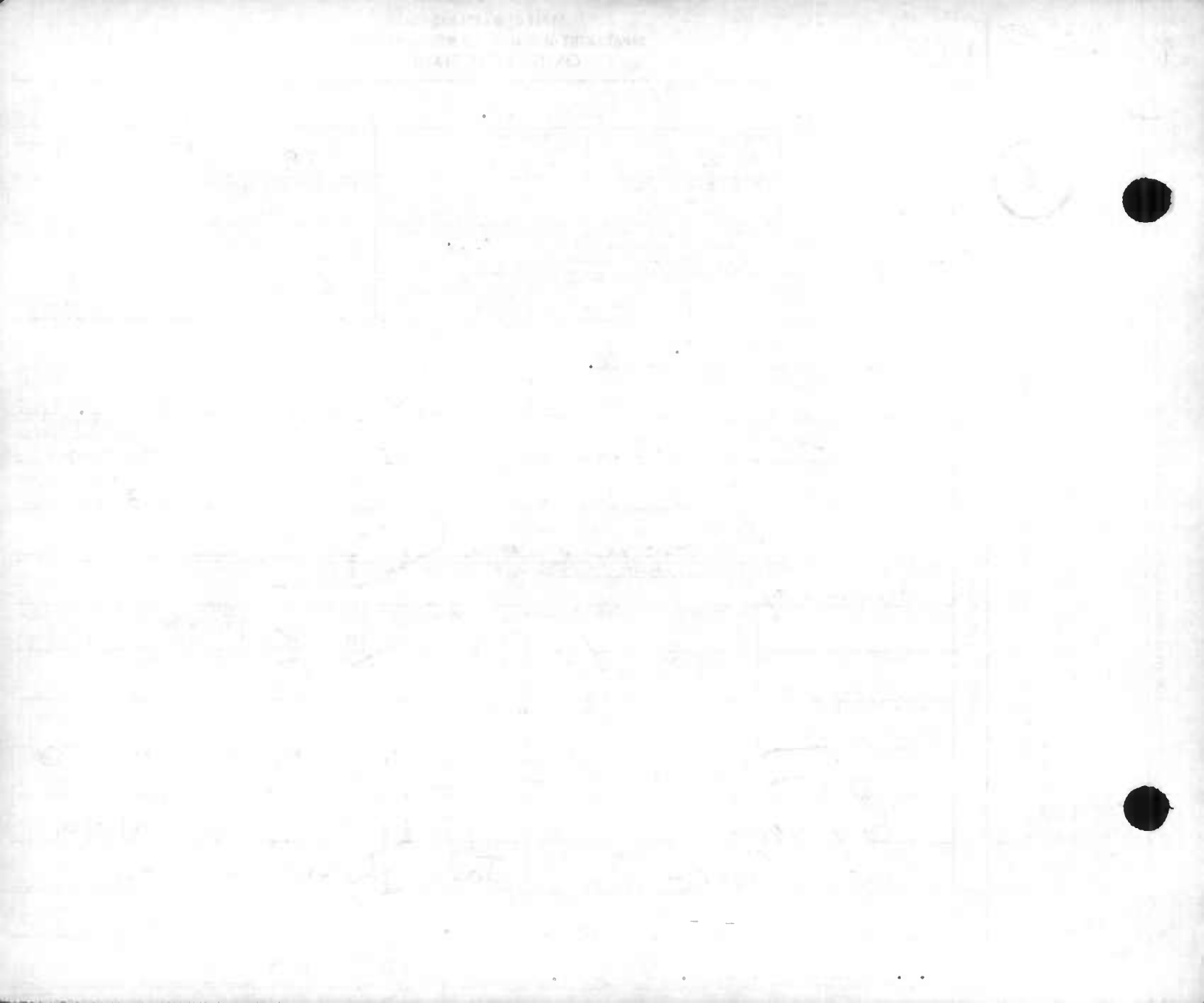
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.




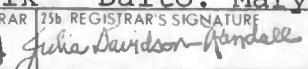
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 32514							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ODELL BROCK JR.						2a. DATE OF DEATH MONTH DAY YEAR 12 13 84		2b. HOUR M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 6 12 45		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 111 HAMLET HILL ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. CITY OR TOWN MARYLAND						13b. COUNTY BALTIMORE		13c. STREET ADDRESS 111 HAMLET HILL ROAD 21210	
14. FATHER'S NAME FIRST MIDDLE LAST ODELL BROCK SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY HAYWARD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS JACQUELINE BROCK 111 HAMLET HILL RD. 21210			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hyperscalcemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>multiple myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~4 minutes ~3 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hyperviscosity</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 19 84</u> to <u>DEC 13 19 84</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive above, (I) <input type="checkbox"/> did not view the body after death, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <u>Gary Gordon</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY GORDON				22e. ADDRESS JOHNS HOPKINS HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT		23b. DATE 12-17-84		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CENT.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS				ADDRESS 1721 N. MONROE ST.		25a. DATE REC'D. BY REGISTRAR DEC 18 1984			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3 2 5 1 5 REG. NO.	
1- STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) Frank William Brodka										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12/20/19 84	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH 11 DAY 2 YEAR 06	6 AGE (IN YEARS) LAST BIRTHDAY 78 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD 12/20/19 84		2b. HOUR 5:36	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City,					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manitenance-Continental		12b. KIND OF BUSINESS OR INDUSTRY can			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2024 Larkhall Road 21222			
14 FATHER'S NAME FIRST Frank MIDDLE W. LAST Brodka, Jr.										15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Smith LAST Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-01-8000		17. INFORMANT Rae W. Brodka		ADDRESS Same as 13e					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Chronic Obstructive Pulmonary Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant				DATE SIGNED 12/21/84			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/84		23c. NAME OF CEMETERY OR CREMATORY Sacred Ht. Of Jesus		23d. LOCATION CITY OR TOWN Dundalk COUNTY Balto. STATE Maryland					
24 FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				ADDRESS 7922 Wise Avenue Dundalk, MD. 21222		25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE 			

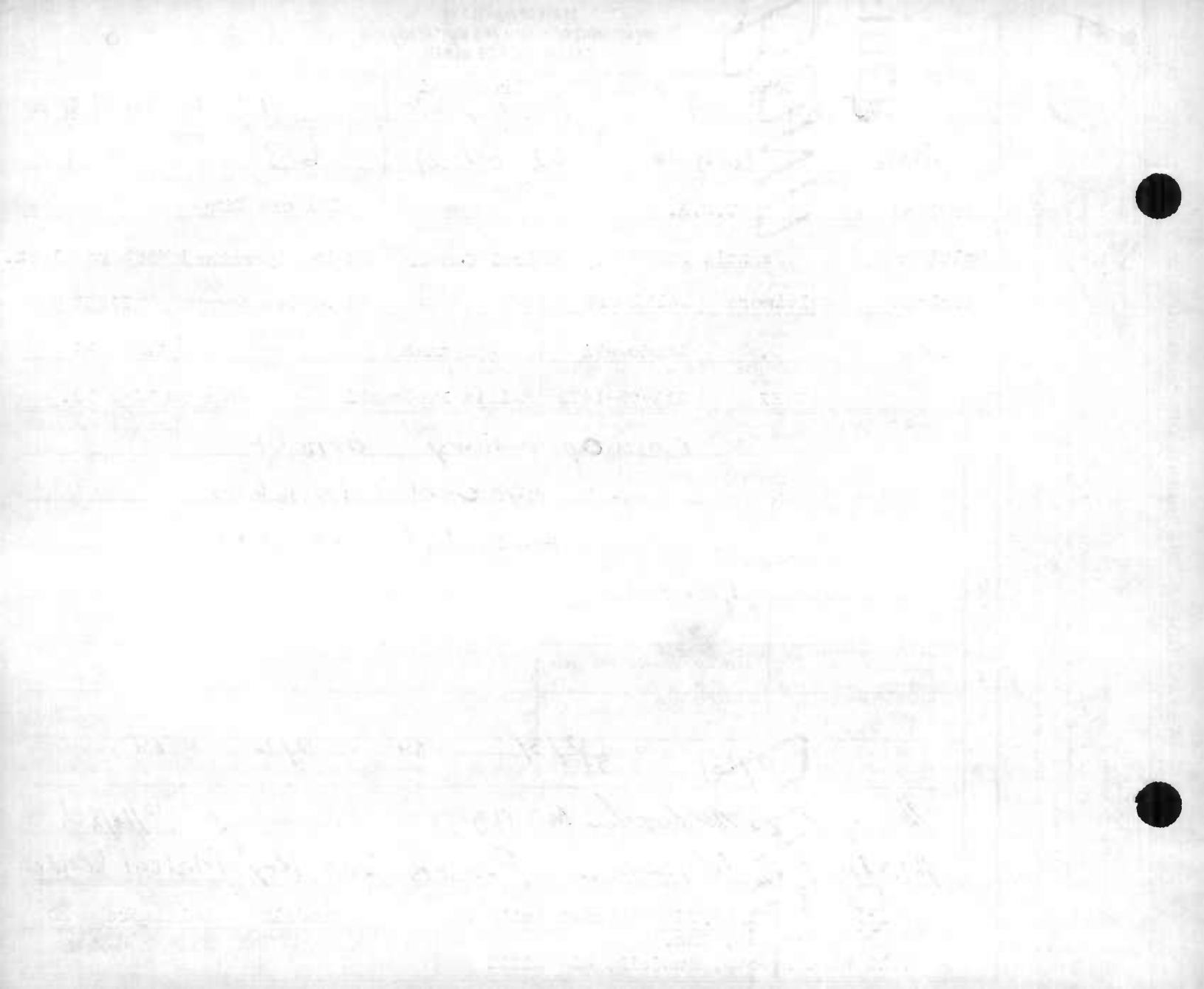


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 5 1 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) John Adam Brodowski			2a. DATE OF DEATH MONTH DAY YEAR 12 16 84			2b. HOUR 11:31 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 04 21		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Western Elect.			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 91 Avalon Avenue 21222			
14. FATHER'S NAME FIRST MIDDLE LAST John W. Brodowski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maryanna Sakowski							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 219-05-1472		17. INFORMANT Emilia Brodowski				ADDRESS Same as Line 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial irritability DUE TO, OR AS A CONSEQUENCE OF (c) myocardial infarction PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/13/84 , 19 84 , to 12/16 , 19 84 , that (I) (we) last saw the deceased alive on 12/16/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael B. White M.D. PhD				DEGREE M.D. PhD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael B. White				22e. ADDRESS Francis Scott Key Medical Center							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/84		23c. NAME OF CEMETERY OR CREMATORY Christ Lutheran				23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Baltimore MD			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				ADDRESS 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR DEC 19 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

3 2 5 1 7

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST				
MORRIS		M.		BRODSKY	12 04 84			1030 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. IF UNDER 1 YEAR		
MALE	CAUCASIAN	MONTH DAY YEAR 06 18 66		78 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	USA			Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	SINAI HOSPITAL			ASST. COMPTROLLER		STATE OF MD		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
MD		BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6816 Williamson Ave #21215				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST MAURICE BRODSKY		FIRST MIDDLE LAST FANNIE SCHERR						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
YES <input checked="" type="checkbox"/> (UNKNOWN) <input type="checkbox"/> WWII		212-05-4948		MRS. IRENE BRODSKY 6816 WILLIAMSON AVE., BALTO., MD 21215				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/28/84</u> to <u>12/4/84</u> , that (I) (we) last saw the deceased alive on <u>12/4/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		
MEENAKSHI PATEL		MD				12/4/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
MEENAKSHI PATEL		SINAI HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL		DEC. 5, 1984		CHEVRA AHAVAS CHESD		RANDALLSTOWN BALTO. MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE RECEIVED BY REGISTRAR 12 7 1984 REGISTRAR'S SIGNATURE				

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 5 1 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
BERNICE JOYCE BROOKS								<input checked="" type="checkbox"/> MATED		12		27		19		84	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	Black	12-31-47		36 YRS.						12		27		19		84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND		USA				Baltimore City											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		So. Balto. Gen. Hosp. (DOA)		FLORAL Designs		Florist											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		A.A.		BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6009 Ritchie Hwy.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
JERRY J. BROOKS		BERNICE E. BROOKS		817-46-2812		Bernice F Brooks		6009 Ritchie Hwy.									
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		817-46-2812		Bernice F Brooks		6009 Ritchie Hwy.											
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Gunshot wound of head (unspecified weapon)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
				DUE TO, OR AS A CONSEQUENCE OF													
				(b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.</u>													
				DUE TO, OR AS A CONSEQUENCE OF													
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
11:55M. 12-26-1984		Subject shot.															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
(van) - yard		6009 Ritchie Hwy.		Anne Arundel, Md													
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		12-27-84											
Ann M. Dixon, M.D.		M.D. Assistant		MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., Md. 21201													
23a. BURIAL CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		12/31/84		Mt Calvary		Brooklyn		AA		md							
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Funell B. Oden		-1631 Druid Hill		DEC 28 1984		Julia Davidson-Randall											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE SENT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

20% COTTON FIBER

WELLS



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 5 1 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS BROOKS			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-31-84			2b. HOUR M 1:33A		
3. SEX MALE	4. RACE COL	5. DATE OF BIRTH MONTH DAY YEAR 1-29-29	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 55	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-31-84		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK (MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21201 1100 BALTON ST APT 510		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BROOKS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET YOUNG				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 214 24 3185		17. INFORMANT ADDRESS MRS HARRIETT BROOKS 1637 BOOKER CT 21217				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) M.D. Assistant					DATE SIGNED 12-31-84	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-4-85		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST V. ACEN			23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS BALTO Co. MD	
24. FUNERAL DIRECTOR NAME ADDRESS JOSEPH L. RUSSELL 2222 W. NORTH AVE				25a. DATE REC'D. BY REGISTRAR JAN 4 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item #161 fg598-12/20/84 JS

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 2 5 2 0
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Danielle T. Brown			2a. DATE OF DEATH MONTH 12 DAY 3 YEAR 84 HOUR 4 MIN 15 PM		
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 1 DAY 10 YEAR 80	6. AGE (IN YEARS LAST BIRTHDAY) 4 YRS.	# UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Miss	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) child		12b. KIND OF BUSINESS OR INDUSTRY
13a. VISUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland COUNTY Baltimore CITY OR TOWN Baltimore			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13c. STREET ADDRESS / ZIP CODE 12 Asgard Ct. 21234					
14. FATHER'S NAME FIRST Sterling MIDDLE N. LAST Brown			15. MOTHER'S MAIDEN NAME FIRST Christiane MIDDLE J. LAST Helou		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-06-6789		17. INFORMANT ADDRESS Sterling N. Brown- Same as #13c	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **cardiac arrest**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Respiratory arrest**

DUE TO, OR AS A CONSEQUENCE OF

(c) **metastatic medulloblastoma**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 min.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

NONE

19a. DATE OF OPERATION 9 NOV 84	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hydrocephalus	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY NONE HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) NONE	
21d. INJURY OCCURRED N/A WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A	21f. LOCATION STREET N/A CITY OR TOWN N/A COUNTY N/A STATE N/A	
22a. I certify that (I) (this hospital) attended the deceased from 8 OCT 19 84 to 3 DEC 19 84 , that (I) (we) last saw the deceased alive on 3 DEC 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.			
22b. SIGNATURE Martha G. Sheridan MD		DEGREE MD	22c. DATE SIGNED 3 Dec 84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martha G. Sheridan		22e. ADDRESS Univ of Md Hospital 22 S. Greene St. Balt, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-6-84	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION CITY OR TOWN Timonium COUNTY Baltimore STATE Maryland
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. ADDRESS Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR DEC 7 1984	25b. REGISTRAR'S SIGNATURE J. Davidson-Randall

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 5 2 1

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLOSSIE BROWN			2a DATE OF DEATH MONTH DAY YEAR December 3, 1984		2b HOUR 5:29a
3 SEX FEMALE	4 RACE NEGROID	5 DATE OF BIRTH MONTH DAY YEAR MAY 4, 1921		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD. 13b COUNTY BALTO.		13c CITY OR TOWN BALTO.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 1726 N. Washington St. 21213	
14 FATHER'S NAME FIRST MIDDLE LAST GEORGE MCGILL		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BARR			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 237-22-4043	17 INFORMANT ADDRESS John Brown 1726 N. Washington St.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: gall bladder disease					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 12/3/84 , 19____, to 12/3/84 , 19____, that (I) (we) lost saw the deceased alive on 12/3/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Mindy Shapiro		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 12/3/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Mindy Shapiro		22e ADDRESS Hopkins Hosp.			
23a SPECIAL CREATION, REMOVAL (SPECIFY)	23b DATE 12-7-84	23c NAME OF CEMETERY OR CREMATORY St. James Ept. ch.	23d LOCATION CITY OR TOWN COUNTY STATE Hemingway S. Fordell		
24 FUNERAL DIRECTOR NAME Wm. J. SPICER		ADDRESS 1637 N. Broadway		25a DATE REC'D. BY REGISTRAR DEC 4 1984	

MEDICAL CERTIFICATION

2

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

8 203 95 38

BROWN, FLOSSIE

20010101 01010101



20010101 01010101

8 500 00 00 00

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

894

3 2 5 2 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Giles E. Brown			7a. DATE OF DEATH MONTH DAY YEAR 12 14 84			7b. HOUR 10:15 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 30 08		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist		12b. KIND OF BUSINESS OR INDUSTRY Gov't	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hatch		13e. STREET ADDRESS / ZIP CODE 505 Old Orchard Rd. 21229			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 532-26-3782		17. INFORMANT Mrs. Helen Brown Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Asystole</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of the bladder & mets</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Frozen Pelvis; Congestive Heart failure, UTI</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> 19 <u>84</u> to <u>12/14</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Ambachew Woreta MD</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMBACHEW WORETA		22e. ADDRESS ST AGNES HOSPITAL, Balto. Md 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/15/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				25a. DATE REC'D. BY REGISTRAR Balto., Md. DEC 19 1984			
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodella</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10:10 AM 11 ST

no

11:10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 5 2 3
REG. NO.

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) A.K.A. Joseph R. Brown		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 12-23-84		2b. HOUR 12:00	
3. SEX M	4. RACE B	5. DATE OF BIRTH 12 7 35	6. AGE (IN YEARS) 49 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 12-23-84	2d. HOUR 12:00
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University HospitalSTU		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Jr. Courier		12b. KIND OF BUSINESS OR INDUSTRY co 000000	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE New York		13b. COUNTY Westchester		13c. CITY OR TOWN Valhalla		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phyllis Phyllis Deas Deans		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO. 228-44-5796		17. INFORMANT ADDRESS Lee F/H 160 Fisher Ave. White Plains, NY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8PM 12-22-84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) driver of auto who crossed median impacting another vehicle			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.		21f. STREET CROSSROADS JFK 300ft. S. of King Ave White Marsh, Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Margate McHale		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 12-23-84	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/85		23c. NAME OF CEMETERY OR CREMATORY White Plains Rural Cem		23d. LOCATION CITY OR TOWN COUNTY STATE White Plains NY	
24. FUNERAL DIRECTOR NAME ADDRESS W.C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 31 1984			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

100

WALKER

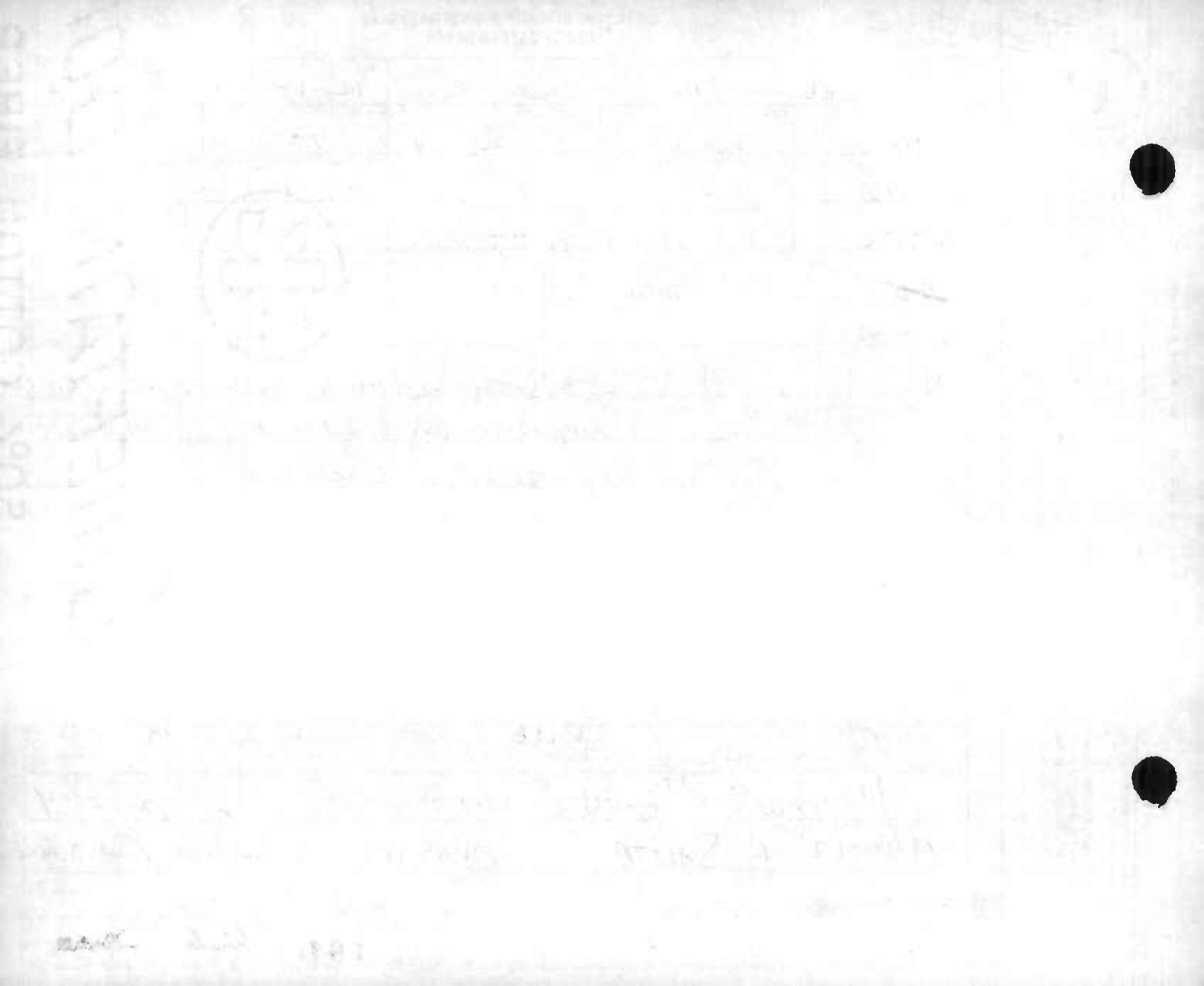
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SALE NOTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to autops.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 5 2 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEE H. Brown				2a. DATE OF DEATH MONTH DAY YEAR 12-18-84		2b. HOUR 4:15 A M	
3. SEX m		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 25 14		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1029 Wicklow Rd 21229							
14. FATHER'S NAME FIRST MIDDLE LAST Junisus Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet Worrell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212/14/0643		17. INFORMANT ADDRESS Carolyn L. Cornish 2522 Edgewood Cir Nw			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) hepatocellular carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) hepatitis B APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 12/16 , 19 84 to 12/18 , 19 84 , that (1) we lost saw the deceased alive on 12/17 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (they) did not view the body after death.							
22b. SIGNATURE Michael R. Saitta				DEGREE MD		22c. DATE SIGNED 12-18-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL R SAITTA				22e. ADDRESS JOHNS HOPKINS Hospital / Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/84		23c. NAME OF CEMETERY OR CREMATORY Cemetery Hill Cem.		23d. LOCATION COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME 1101 E. North Avenue Wm C March H. H.				25a. DATE RECD. BY REGISTRAR DEC 19 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		3 2 5 2 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MAZZIE BROWN		FIRST MAZZIE MIDDLE LAST BROWN		DATE DECEMBER 13 1984 2b. HOUR 6 31 A.M.	
3. SEX F FEMALE	4. RACE NEGRO	5. DATE OF BIRTH JUNE 10, 1904		6. AGE (LAST BIRTHDAY) 80 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN FACILITY, GIVE STREET AND STREET NO.) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND		13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 3912 WEST GARRISON AVE 21215 3912 West GARRISON AVE.	
14. FATHER'S NAME GEORGE MIDDLE		15. MOTHER'S MAIDEN NAME CREECY MIDDLE		16. ADDRESS BLANCHE MIDDLE ALSTON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 239-32-9990		17. INFORMANT MARTHA JOHNSON/3912 W. GARRISON AVE. 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DIABETES					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/04/1984 19 84 , to 12/13 19 84 , that (I) (we) lost saw the deceased alive on 5:25 AM 12/13/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE R. Brem		DEGREE		22c. DATE SIGNED 12/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. BREM		22e. ADDRESS SINAI HOSPITAL, BALTO, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM.	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		23e. DATE REC'D. BY REGISTRAR DEC 19 1984			
24. FUNERAL DIRECTOR MARSHALL W. JONES, JR.		25a. DATE REC'D. BY REGISTRAR DEC 19 1984		25b. REGISTRAR'S SIGNATURE Julian Davidson-Rand	
4101 EDMONDSON AVE./BALTO., Md. 21229					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 2 6
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) THELMA ANNA BROWN			2a. DATE OF DEATH MONTH DAY YEAR 12 24 84		2b. HOUR 326 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 4 18 14		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator	12b. KIND OF BUSINESS OR INDUSTRY L Gordon & Son	
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Franklin Kelly			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-34-6889		17. INFORMANT ADDRESS George F. Brown 1135 Scott Street 21230	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral haemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12 23</u> , 19 <u>84</u> , to <u>12 24</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12 24</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Vriesendorp</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 12/24/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VRIESENDORP				22e. ADDRESS Univ. of Md Hospital Neurol. S. Greene St. Baltimore Dep	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/84	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR DEC 26 1984	25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodell	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



WARRAND

Unit of Mr. H. H. H.

Admission Card

Baltimore

Baltimore

Industrial Department

X

12/12/21

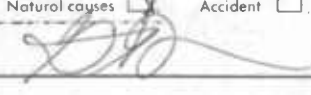

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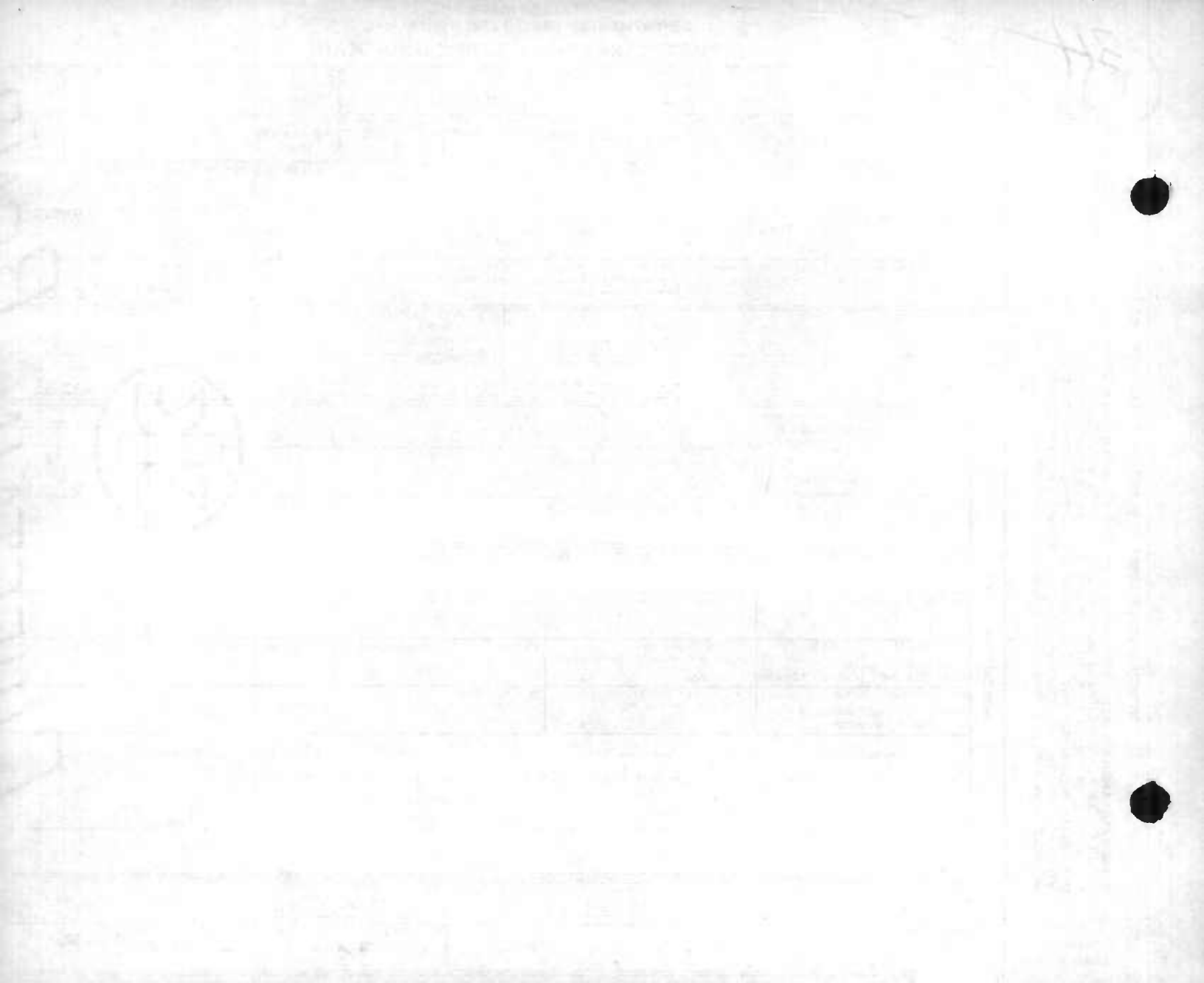
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 5 2 7
REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas H. Brown			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12/ 7/ 19 84			2b. HOUR 3:10					
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 9 6 1912		6. AGE (IN YEARS) (LAST BIRTHDAY) YEARS MONTHS DAYS 72		7. IF UNDER 1 YR. IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2207 Federal St.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE Md			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2207 E. Federal Street			13f. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13g. STREET ADDRESS 21213		
14. FATHER'S NAME FIRST MIDDLE LAST Wesley Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Cook			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 218-07-0525		
17. INFORMANT Dorothy Middleton			17. ADDRESS 2207 E. Federal St			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			TITLE (SPECIFY) Assistant			DATE SIGNED 12/7/84					
ACTUAL SIGNATURE 			M.D. Gregory R. Kauffman, M.D.			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/11/84			23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA			23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md		
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave			ADDRESS 1101 E. North Ave			25a. DATE REC'D. BY REGISTRAR DEC 11 1984			25b. REGISTRAR'S SIGNATURE 		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) Zola Gladys Brown					2a. DATE OF DEATH MONTH DAY YEAR 12 30 84					2b. HOUR 6 A M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 16 1903			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 11 11 11 11	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1743 North Carey Street					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Factory Worker	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1743 N. Carey St. Baltimore, Maryland 21217			
14. FATHER'S NAME FIRST MIDDLE LAST Charles R. Bailey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Dashiels							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. 219-05-3543		17. INFORMANT ADDRESS 2504 Kirtland Avenue Oliver Hull Forrestville, Maryland 20028					
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency - Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Heart Failure - Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Aortic - Valvular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 19 72 18 84					
22a. I certify that (I) the physician attended the deceased from Nov 28th 1984 to Nov 18 1984 , that (I) we last saw the deceased alive on Nov 18 1984 , and that (I) we saw the body after death.											
22b. SIGNATURE [Signature]				DEGREE Modern Parkway East Medical Center ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-8-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]				22e. ADDRESS Baltimore, Maryland 21239							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 4, 1985		23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Maryland			
24a. FUNERAL HOME NAME Nutter & Sons				24b. ADDRESS 2501 Gwynns Falls Parkway				24c. CITY OR TOWN Baltimore		24d. STATE Maryland	
25a. DATE REC'D. BY REGISTRAR Jan 7 1985				25b. REGISTRAR'S SIGNATURE [Signature]							

BP



No.	Residence	Age	Sex	Occupation	Address
1	Female	12	Black	1743 North Carey Street	Baltimore, Maryland
2	Male	12	Black	1743 North Carey Street	Baltimore, Maryland
3	Male	12	Black	1743 North Carey Street	Baltimore, Maryland
4	Male	12	Black	1743 North Carey Street	Baltimore, Maryland
5	Male	12	Black	1743 North Carey Street	Baltimore, Maryland
6	Male	12	Black	1743 North Carey Street	Baltimore, Maryland
7	Male	12	Black	1743 North Carey Street	Baltimore, Maryland
8	Male	12	Black	1743 North Carey Street	Baltimore, Maryland
9	Male	12	Black	1743 North Carey Street	Baltimore, Maryland
10	Male	12	Black	1743 North Carey Street	Baltimore, Maryland

1. Mr. A. J. ...
2. Mr. ...
3. Mr. ...
4. Mr. ...
5. Mr. ...
6. Mr. ...
7. Mr. ...
8. Mr. ...
9. Mr. ...
10. Mr. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

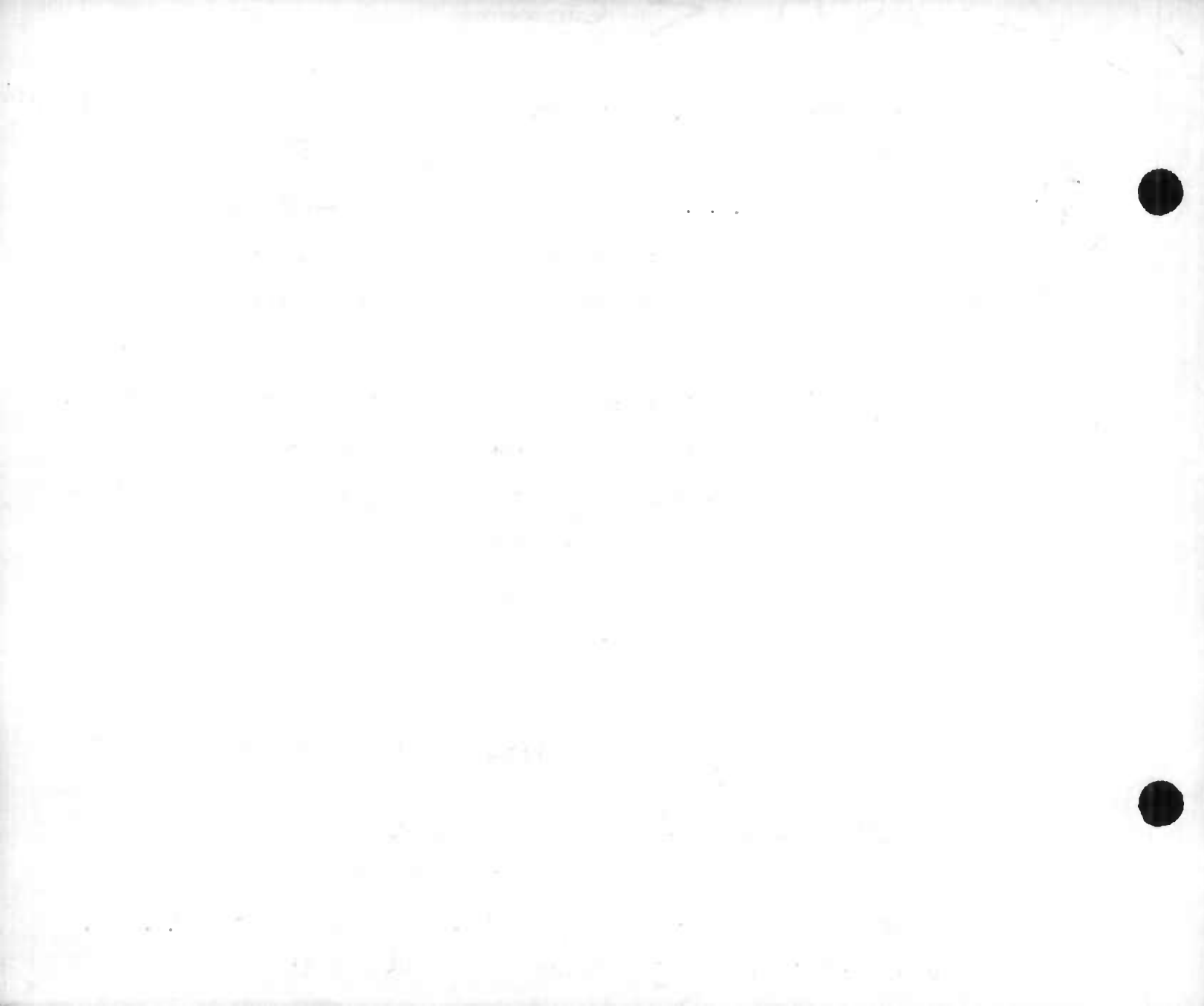
REG. NO.

3 2 5 2 9

1- FOR
STATE
REGISTRAR AKA-WATHA BRUMBLES

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WATHA N. BRUMBLES			2a DATE OF DEATH MONTH DAY YEAR 12-29-84			2b HOUR 1:57 PM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 3 29 26		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7 IF UNDER 1 YEAR MONTHS DAYS 8 10	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Layer		12b KIND OF BUSINESS OR INDUSTRY Pridemark Homes	
13a STATE Maryland			13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Charlie Brumbles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fauline Acoc					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES) WW II		17 INFORMANT ADDRESS Opal Xanthakos 1021 Tricking Brook Rd. 21030				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensated myocardial failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Shock lung (ARDS) - respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gram negative Septicemic Shock</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins "days" "days"	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic emphysematous lung. Cirrhosis of liver</u>									
19a DATE OF OPERATION 12/29/84			19b CONDITION FOR WHICH OPERATION WAS PERFORMED Poor, shocky			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 11/26/ 19 84 12/9/ 19 84				
22a I certify that (this hospital) attended the deceased from <u>11/26/ 19 84</u> to <u>12/9/ 19 84</u> , that (we) last saw the deceased alive on <u>12/9/ 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>[Signature]</u> MD				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 12/9/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. CHANARONG MD				22e ADDRESS BON SECOURS HOSPITAL					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 12/13/84		23c NAME OF CEMETERY OR CREMATORY Cheltenham Vet. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.		
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.				24b ADDRESS 121229 4107 Wilkens Ave.		25a DATE REC'D. BY REGISTRAR DEC 12 1984		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 5 3 0	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Leroy BRUNSON					2a. DATE OF DEATH MONTH DAY YEAR December 11, 1984			2b. HOUR A M 10:30			
3. SEX M		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 3 2 15		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (THE WORK OR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balt.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 416 E. Eager Rd 21202			
14. FATHER'S NAME FIRST MIDDLE LAST Walter Brunson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elmira Haley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS Ether Brunson 152 Japcott St Bklyn N.Y.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete heart Block DUE TO, OR AS A CONSEQUENCE OF, (b) Myocardial infarction; Hypotension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF, (c) Dehydration, metabolic acidosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Rule out pulmonary embolism. right cerebrovascular accident.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) (this hospital) attended the deceased from December 7, 19 84 , to December 11, 19 84 , that (X) (we) last saw the deceased alive on December 11, 19 84 , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Shoaib Hashmi		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 12/11/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Shoaib Hashmi, M.D.		22e. ADDRESS c/o Maryland General Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY Silver Mt.		23d. LOCATION STREET CITY COUNTY STATE Station St N.Y.					
24. FUNERAL DIRECTOR NAME Locks Funeral Home		ADDRESS 1304 N. Central		25a. DATE REC'D. BY REGISTRAR DEC 18 1984		25b. REGISTRAR'S SIGNATURE Jana Davidson-Hendell					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Harry A. Bryan</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-19-84</i>			2b. HOUR <i>1:15 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8-30-32</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Balto. General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i>			13b. COUNTY		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6056 Moravia Pk. Dr. Apt. B3</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Bryan</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Riddie Ayers</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>176-20-6148</i>		17. INFORMANT ADDRESS <i>Geraldine Bryan 6056 Moravia Pk. Dr. Apt. B3</i>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>MYOCARDIAL INFARCTION</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes Mellitus</i>							
19a. DATE OF OPERATION <i>-</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5:22</i> <i>12</i> <i>19</i> <i>84</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from <i>5/22</i> , 19 <i>84</i> , to <i>Dec</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>12/17</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>John Surge</i>		DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>INDEN SINGH</i>		22e. ADDRESS <i>2301 Annapolis Rd. Balto</i>			

23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) <i>Burial</i>		23b. DATE <i>12-22-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Garrison Forest Va.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Owings Mills Md.</i>	
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24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H 1101 E. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 26 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 5 3 2	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR		
1. DECEASED NAME (TYPE OR PRINT) Leona Mae Buckingham			12-29-84		2b. HOUR 8:19 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1907	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Cntr.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker	12b. KIND OF BUSINESS OR INDUSTRY -----		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13a. STATE Maryland	13b. COUNTY -----	13c. CITY OR TOWN Baltimore	13e. STREET ADDRESS / ZIP CODE 1117 Steelton Ave. 21224		
14. FATHER'S NAME FIRST MIDDLE LAST Israel M. Silkworth			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Porter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----	17. INFORMANT ADDRESS Baltimore, Md. 21222 Georgia Silkworth 8010 Charlesmont			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of lung; metastatic to liver DUE TO, OR AS A CONSEQUENCE OF (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Dec. 20, 1984, to Dec. 29, 1984, that (I) (we) last saw the deceased alive on Dec. 29, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.					
22b. SIGNATURE Daniel M. Perlman MD		DEGREE MD		22c. DATE SIGNED 12-29-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL M. PERLMAN		22e. ADDRESS Francis Scott Key Medical Ctr. Balt. 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan 3, 85	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc.		ADDRESS 7110 Belair Road Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 2 1985	



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 5 3 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AGNES B. BUDNICK				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 19, 1984			
3. SEX FEMALE				4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6/04/04	
6. AGE (IN YEARS LAST BIRTHDAY) 80				7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER PENNA AVE NURSING	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE'S AIDE				12b. KIND OF BUSINESS OR INDUSTRY MEDICAL		13a. STREET ADDRESS 201 N. WASHINGTON ST. 21231	
13b. STATE MARYLAND				13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BRAUN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET MEDDLING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-50-4975		17. INFORMANT ADDRESS MS. PAT AHRENBURG 4717 WASH. BLVD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adeno Carcinoma of Spine & Brain</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Atherosclerotic Cardiovascular disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-11-84</u> to <u>12-19-84</u> , that (I) (we) lost saw the deceased alive on <u>12-12-84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12-20-84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DARSHAN S. SALUJA MD		22e. ADDRESS 1600 MT Royal Ave, Baltimore 21217					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/22/84		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE DORSEY HOWARD MARYLAND	
24. FUNERAL DIRECTOR NAME AMBROSE, INC.		24b. ADDRESS 1328 SULPHUR SPRING ROAD		25a. DATE REC'D. BY REGISTRAR DEC 20 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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1910 John W. ...



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 5 3 4					
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) JUNE					FIRST NM					LAST BUFFALO					
3. SEX Male			4. RACE Black			5. DATE OF BIRTH MONTH 3 DAY 8 YEAR 82			6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS			7a. DATE OF DEATH MONTH DAY YEAR 12 17 84		7b. HOUR 1 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CITY, BALTO MD.						
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSP							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOOKER/RIGGER			12b. KIND OF BUSINESS OR INDUSTRY BETH STEEL		
13a. STATE MARYLAND					13b. COUNTY BALTO		13c. CITY OR TOWN BALTO			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1707 DAVID HILL AVE 21217			
14. FATHER'S NAME FIRST CHARLES MIDDLE LAST BUFFALO					15. MOTHER'S MAIDEN NAME FIRST VIRGINIA MIDDLE NM LAST PERKINS										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN					16b. SOCIAL SECURITY NO. 245-01-4049			17. INFORMANT ADDRESS MEDICAL RECORDS UMH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> , 19 <u>84</u> , to <u>12/17</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Scott A. Berger MD								DEGREE MD.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/17/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Scott A Berger MD								22e. ADDRESS UNIV. OF MARYLAND HOSP - INT. MEDICINE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/30/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.					
24. FUNERAL DIRECTOR NAME CHATMAN-HARRIS FH ADDRESS 1701 MCGILL ST								25a. DATE REC'D. BY REGISTRAR DEC 18 1984		25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 5 3 5			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jesse Bumbray, Sr.				2b. HOUR 8:10 P.M.			
3. SEX male		4. RACE Balto		5. DATE OF BIRTH MONTH DAY YEAR 2 1 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE md				13b. COUNTY Balto.		13c. CITY OR TOWN Denton Nursing Home	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Bumbray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 213-36-2738		17. INFORMANT ADDRESS East Windsor, N.J. 749 Twinivers Dr. N.J.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) prolonged bed ridden patient							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/06/84, 19 to 12/18/84, 19 84, that (I) (we) last saw the deceased alive on 12/18/84, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jean Albert Midy MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jean Albert Midy MD				22e. ADDRESS 549 N. Fulton Ave Balto MD 21223			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/27/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Landsdown, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H ADDRESS 1101 E. North Ave.				25a. DATE REC'D BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3--4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or his delegate will be notified of this.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 3 6
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
F		VIRGINIA DUVALL BUOEY		12 / 26 / 84		5		15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		WHITE		12 / 30 / 32		51 YRS.		MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
PENNA.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		UNIV. OF MARYLAND HOSPITAL		Housewife		Own/Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		CECIL		KIDGINGTON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14 WILSON AVE P.O. Box 579	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
BROWN		A. DUVALL		NONA		STEWART			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (HUSBAND)		ADDRESS			
No		168-24-6718		HERMAN C. BUOEY		SAME AS #13			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Inability to come off the pump</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CAHHD + ? MT.</u>			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
12/26/84		Coronary artery disease		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/26/1984</u> to <u>12/26/1984</u> , that (I) (we) last saw the deceased alive on <u>12/26/1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
S. Agazarian		MD.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
AGHAZARIAN S		MD. UNIV. HOSPITAL					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		12/31/84		LONGWOOD CEMETERY		KENNETT SQUARE CHESTER PA.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
E. BARNES		21018		DEC 31 1984		Julia Davidson-Randall	
FLEMING FUNERAL SERVICE		BENSON, MD.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

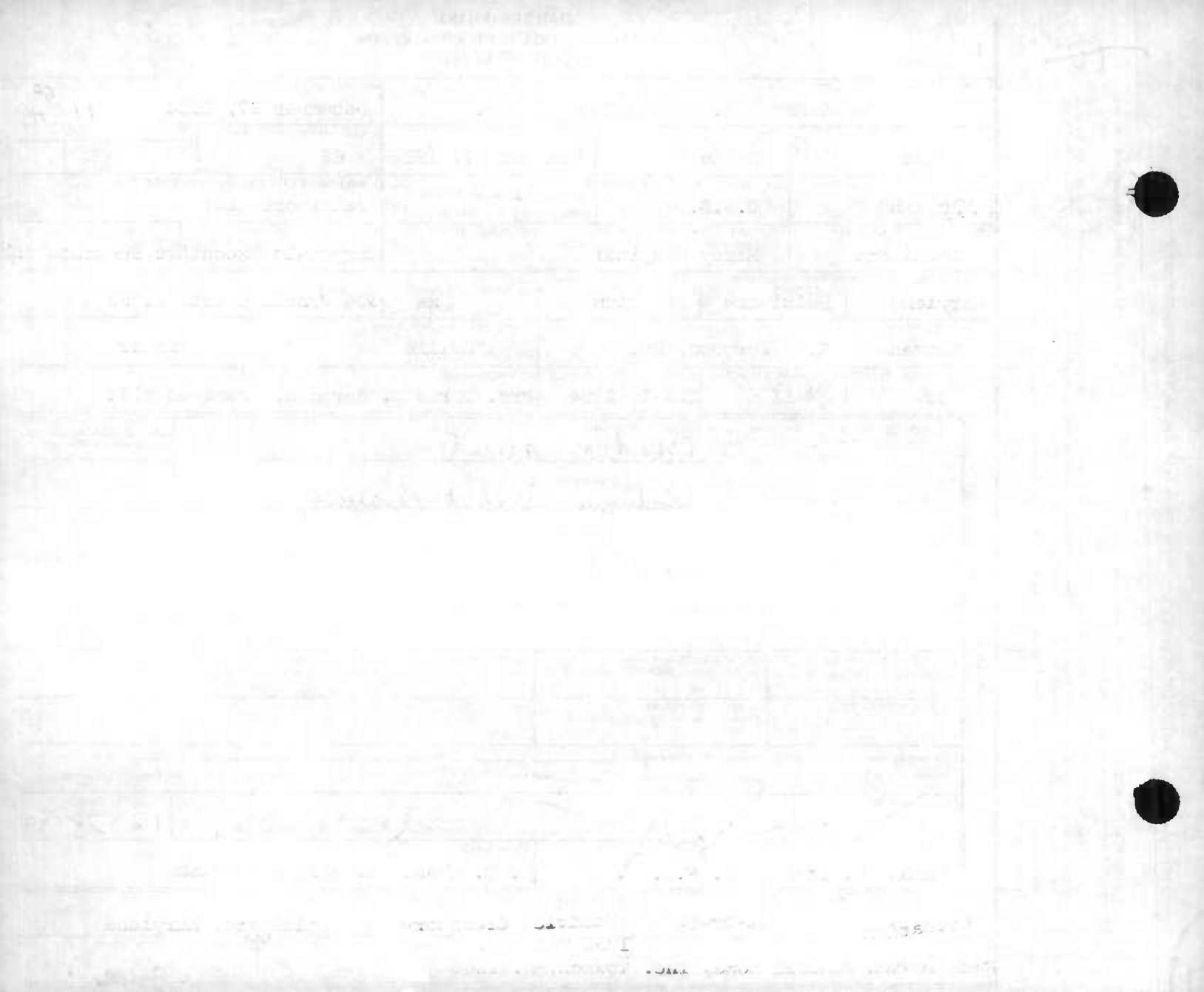
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 5 3 7			
1. DECEASED NAME (TYPE OR PRINT) NORMAN A. BURGOON, JR.				2a. DATE OF DEATH MONTH DAY YEAR December 27, 1984		2b. HOUR 11 50 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 27, 1916		6. AGE (IN YEARS, LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Corporate Executive		12b. KIND OF BUSINESS OR INDUSTRY Suburban Bank	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Timonium				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Norman A. Burgoon, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Ricker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII		17. INFORMANT ADDRESS Mrs. Doris M. Burgoon, same as #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Schematic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frank W. Davis, Jr.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank W. Davis, Jr. M.D.				22e. ADDRESS 9 E. Chase St. Balto. Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-29-84		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR Jan 2, 1985		25b. REGISTRAR'S SIGNATURE S. J. ...			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
FOR STATE REGISTRAR		REG. NO. 3 2 5 3 8											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLARD C. BURKE						2a. DATE OF DEATH MONTH DAY YEAR 12 19 84			2b. HOUR 12 ²⁷ P. M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 23 1910		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. Separated MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REAL ESTATE BROKER			12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE				
13a. USUAL RESIDENCE (If NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD. - BALTIMORE						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 3545 BELAIR RD. 21213							
14. FATHER'S NAME FIRST MIDDLE LAST LEWIS BURKE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN CROXTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-03-2509		17. INFORMANT ADDRESS MARY WHEELER (STEP-DGHTER) 3012 PELHAM AVE. 21213									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) job myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min. 24 hrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (this hospital) attended the deceased from Dec 19 19 84, to Dec 19 19 84, that (it was) lost above, (it was) did view the body after death.													
22b. SIGNATURE Susan M. Yeomans, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/19/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUSAN M. YEOMANS, M.D.						22e. ADDRESS UNION MEMORIAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL			23b. DATE 12/23/84		23c. NAME OF CEMETERY OR CREMATORY IRVINGTON BAPTIST CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE IRVINGTON VA.					
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. ADDRESS 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR DEC 21 1984						25b. REGISTRAR'S SIGNATURE [Signature]	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1. FOR
STATE
REGISTRAR

REG. NO.

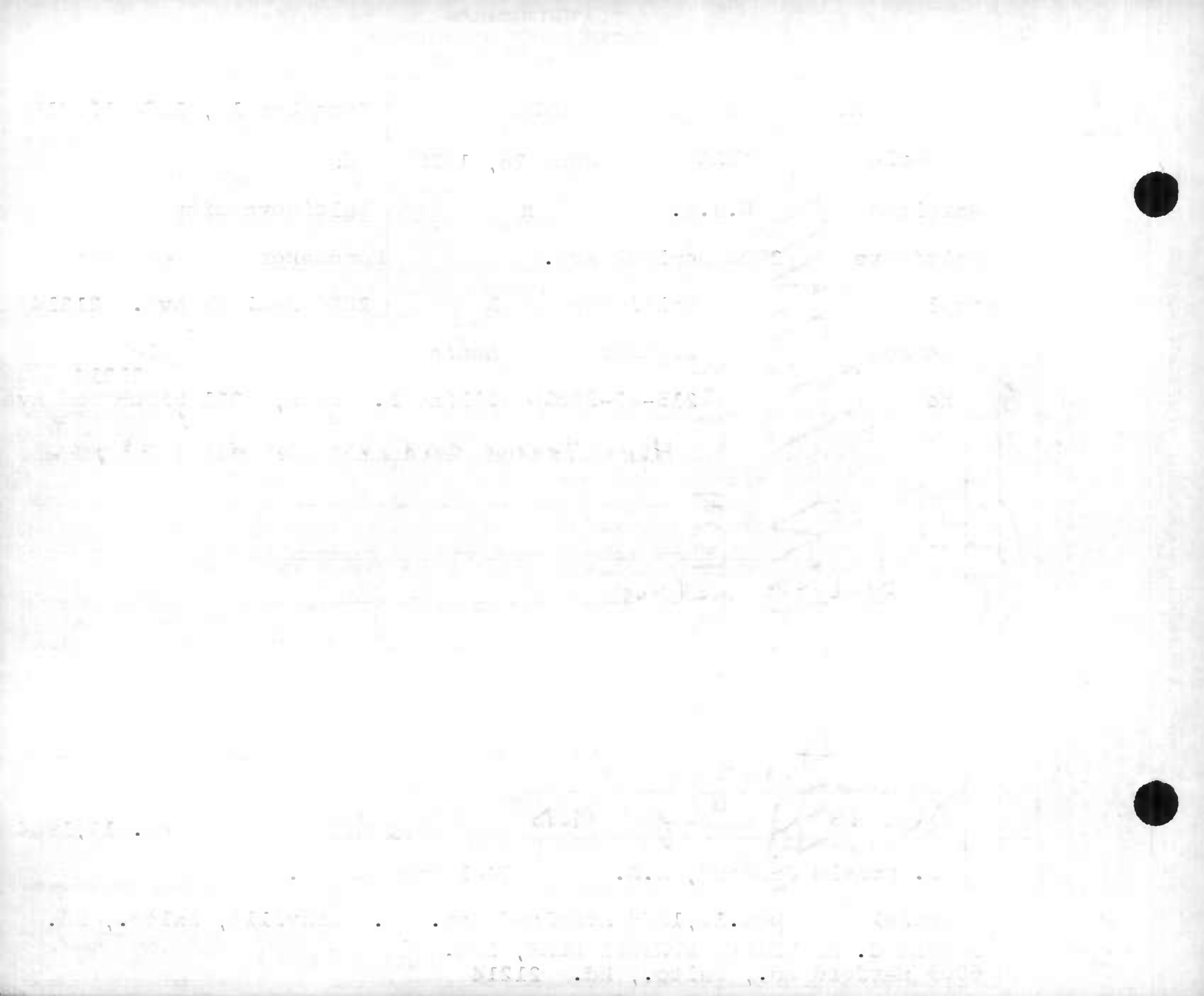
1. DECEASED NAME (TYPE OR PRINT) EVA TERESA BURNS			2a. DATE OF DEATH MONTH DAY YEAR December 16, 1984		2b. HOUR 12:01^P_M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 28, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 85
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2806 Hemlock Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS 2806 Hemlock Ave. 21214			13f. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST George Bittner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Klehm		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-03-5089		17. INFORMANT ADDRESS D William L. Burns, 6221 Birchwood Ave. 21214	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular dis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (was hospital) attended the deceased from Feb 16, 1959 , to Feb. 16, 1984 , that (I) (was) last saw the deceased alive on Sept. 5, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ronald Jandorf		DEGREE M.D.		22c. DATE SIGNED Dec. 17, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Donald Jandorf, M.D.		22e. ADDRESS 7403 Harford Rd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 18, 1984	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md.	
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC.			25a. DATE REC'D. BY REGISTRAR DEC 17 1984		
6009 Harford Rd., Balto., Md. 21214			25b. REGISTRAR'S SIGNATURE Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified of (a) any injury, or other traumatic event, the medical examiner must be notified of (b) any injury, or other traumatic event.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. It is please to use separate forms for separate burials. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal to another place.

IMPORTANT: If item 21 is marked on item 18 above only one medical examiner may be used at a time.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										32540	
1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THELMA D BURRELL						2a. DATE OF DEATH MONTH DAY YEAR 12 18 84			2b. HOUR 2:59PM		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 4 09		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS 75		IF UNDER 24 HRS HOURS MIN. 75	
7a. BIRTHPLACE (STATE OR FOREIGN) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD						13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNK						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola King					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 211-12-9960		17. INFORMANT ADDRESS Daisy Scott 1903 Oakhill Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septic shock DUE TO, OR AS A CONSEQUENCE OF (b) Polymicrobial sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatoid arthritis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Rheumatoid arthritis											
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/14/84 to 12/18/84 that (I) (we) last saw the deceased alive on 12/18/84 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jeff Freeman						DEGREE MD		22c. DATE SIGNED 12/18/84		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeff Freeman						22e. ADDRESS 600 N. WOLFE AVE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial n		23b. DATE 12-22-84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.					
24. FUNERAL DIRECTOR NAME WM. C. March F/H 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR DEC 20 1984					
25b. REGISTRAR'S SIGNATURE John Davidson-Randall											

MEDICAL CERTIFICATION

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1- STATE F#601
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 5 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		3. DATE OF BIRTH		4. AGE (IN YEARS)		5. IF UNDER 1 YR.		6. IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Eugene		12 19 84		7-22-1984		5 YRS.		3 MONTHS		5 DAYS		12 19 84		1:17 PM	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Balto. Md		USA				Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		Provident Hospital		None											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Md		Balto.		Balto.				6727 Tounbrook Drive							
14. FATHER'S NAME (FIRST) MIDDLE LAST		15. MOTHER'S MAIDEN NAME (FIRST) MIDDLE LAST													
Eugene		Queen Esther													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
No				Queen Esther		7use-6727 Tounbrook									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden infant death syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 12/20/84			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn Street, Balto, MD 21201													
23a. BURIAL OR CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial		12/24/84		Garrison Forest		Curinghill Balto. Md									
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Turnell B. Oden - 163 P. Smith Hill		DEC 31 1984		John Davidson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAPERS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE ~~7-111111~~ 7-111111 RECORDS DIVISION OF VITAL RECORDS, 201 W. WELSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR DISPOSAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 5 4 2			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			
HOWARD RICHARD BUTLER, SR.				2a. DATE OF DEATH MONTH DAY YEAR			
3. SEX MALE				4. RACE BLACK			
5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)			
AUG. 26, 1928				56 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
MARYLAND				US of A			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
BALTIMORE CITY				MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
BALTIMORE				796 W. SARATOGA STREET			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
RETIRED				U S POST OFFICE			
13a. STATE				13b. COUNTY			
MARYLAND				BALTIMORE			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
LEONARD BUTLER				CARRIE DOBSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
YES				1946 - 1949			
17. INFORMANT ADDRESS				MRS. MARY E. BUTLER 710 EDGEWOOD ST. 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cholangiocarcinoma, unresectable</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. _____							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST</u> 19 <u>87</u> to <u>12/26</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23a. SIGNATURE				23b. DEGREE			
Neil D. Goldberg				M.D.			
24. PHYSICIAN'S NAME (TYPE OR PRINT)				25. ADDRESS			
Neil D. Goldberg				300 Armory Place suite 3F Baltimore			
26a. BURIAL, CREMATION, REMOVAL (SPECIFY)				26b. DATE			
BURIAL				1/2/85			
27a. NAME OF CEMETERY OR CREMATORY				27b. LOCATION CITY OR TOWN COUNTY STATE			
GARRISON FOREST VET CEM				OWINGS MILLS (BALTO.) MD.			
28. FUNERAL DIRECTOR NAME				29. DATE REC'D. BY REGISTRAR			
LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE				DEC 31 1984			
30. REGISTRAR'S SIGNATURE				31. REGISTRAR'S SIGNATURE			
Julia Davidson-Wendell				Julia Davidson-Wendell			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOSEPH K. BUTLER			2a. DATE OF DEATH MONTH DAY YEAR 12 3 84			2b. HOUR M				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 15 98		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mt. Vernon Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 808 St. Paul St. 21202	
14. FATHER'S NAME FIRST MIDDLE LAST Unkn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Attway Butler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-05-7994		17. INFORMANT ADDRESS Mary Frazier 1215 Young Court					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Organic Brain Syndrome, Parkinsonism</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>7.7. 19 84</u> , to <u>12.3. 19 84</u> , that (I) (we) lost saw the deceased alive on <u>11.16. 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>H. J. L.</u>			DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>12.4.84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. AUJLA</u>			22e. ADDRESS <u>5400 OLD COURT RD, RAN) ALLSTOWN 21133</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/7/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR Wm C March F/H, Inc.					ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 5 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 5 4 4			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WARREN BUTLER				2a. DATE OF DEATH MONTH 12 DAY 31 YEAR 84		2b. HOUR 5:15A M	
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH 9 DAY 11 YEAR 34		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Secunderabad		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH city		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS Hosp.		12a. USUAL OCCUPATION (TYPE OR WORK, OR MOST OF WORKING LIFE) Librarian		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY C 13c. CITY OR TOWN BALTO.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2581 W. Loyeth St. 21223	
14. FATHER'S NAME FIRST Warren MIDDLE Butler LAST				15. MOTHER'S MAIDEN NAME FIRST Alma MIDDLE Smith LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS 2581 W. Loyeth St. Baltimore			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cancer DUE TO, OR AS A CONSEQUENCE OF Cancer of Pitary nx with METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 1146 CITY OR TOWN 84 COUNTY 13/31 STATE 84			
22a. I certify that (I) (this hospital) attended the deceased from 12/31 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Kuang-yen Huang				DEGREE		22c. DATE SIGNED 12/31/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG				22e. ADDRESS BON SECOURS Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-5-84		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn		23d. LOCATION CITY OR TOWN Balto. COUNTY md. STATE	
24. FUNERAL DIRECTOR McCrinnix Funeral Home				25a. DATE REC'D BY REGISTRAR DEC 31 1984 25b. REGISTRAR'S SIGNATURE			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 4 5

3
1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VERONICA BYRNES			2a. DATE OF DEATH MONTH DAY YEAR 12 8 84			2b. HOUR 02²⁵ M		
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 10 16 03	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balti MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3517 Md.		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS ZIP CODE 2601 Roslyn Ave. 216			
14. FATHER'S NAME Michael MIDDLE			15. MOTHER'S MAIDEN NAME Byrnes FIRST			MIDDLE Nolan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 212-62-4516		17. INFORMANT Knesaw N. Horne ADDRESS →				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis								
DUE TO, OR AS A CONSEQUENCE OF (c) Perforated gastric ulcer								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Atherosclerotic Cardiovascular disease								
19a. DATE OF OPERATION 11/14/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Gastric Ulcer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/14/84 to 12/7/84 , that (I) (we) last saw the deceased alive on 12/7/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.								
22b. SIGNATURE Pelegian				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/8/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PEZ040 E. CORREA				22e. ADDRESS LUTHERAN HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-14-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Airy		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME Quin Carolle		ADDRESS 1712 N. North Ave		25a. DATE REC'D. BY REGISTRAR DEC 11 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

60/40

100% Cotton

100% Cotton

100% Cotton

100% Cotton

100% Cotton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 10 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 5 4 6

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST RUFUS CAIN		12/29/84		3:36 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
MALE	BLACK	10/29/14	70	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
VA	USA		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Bon Secour Hospital				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
MD		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST Thomas Cain		FIRST MIDDLE LAST Amanda Beasley		3013 W. Lanvale St. 21216	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		227-09-0358		Rachael Robinson 3013 W. Lanvale St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Squamous Cell Carcinoma Lung</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>B. pneumoniae</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE		DEGREE		22c. DATE SIGNED	
Frank A. Hamilton, MD				12-29-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Barad Gonzales / Frank A. Hamilton		2000 W. Baltimore St. Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		1/4/85	Cedar Hill Cem.		CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.		DEC 31 1984		John Davidson-Randall	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 5 4 7
REG. NO.

1- FOR
STATE
REGISTRAR

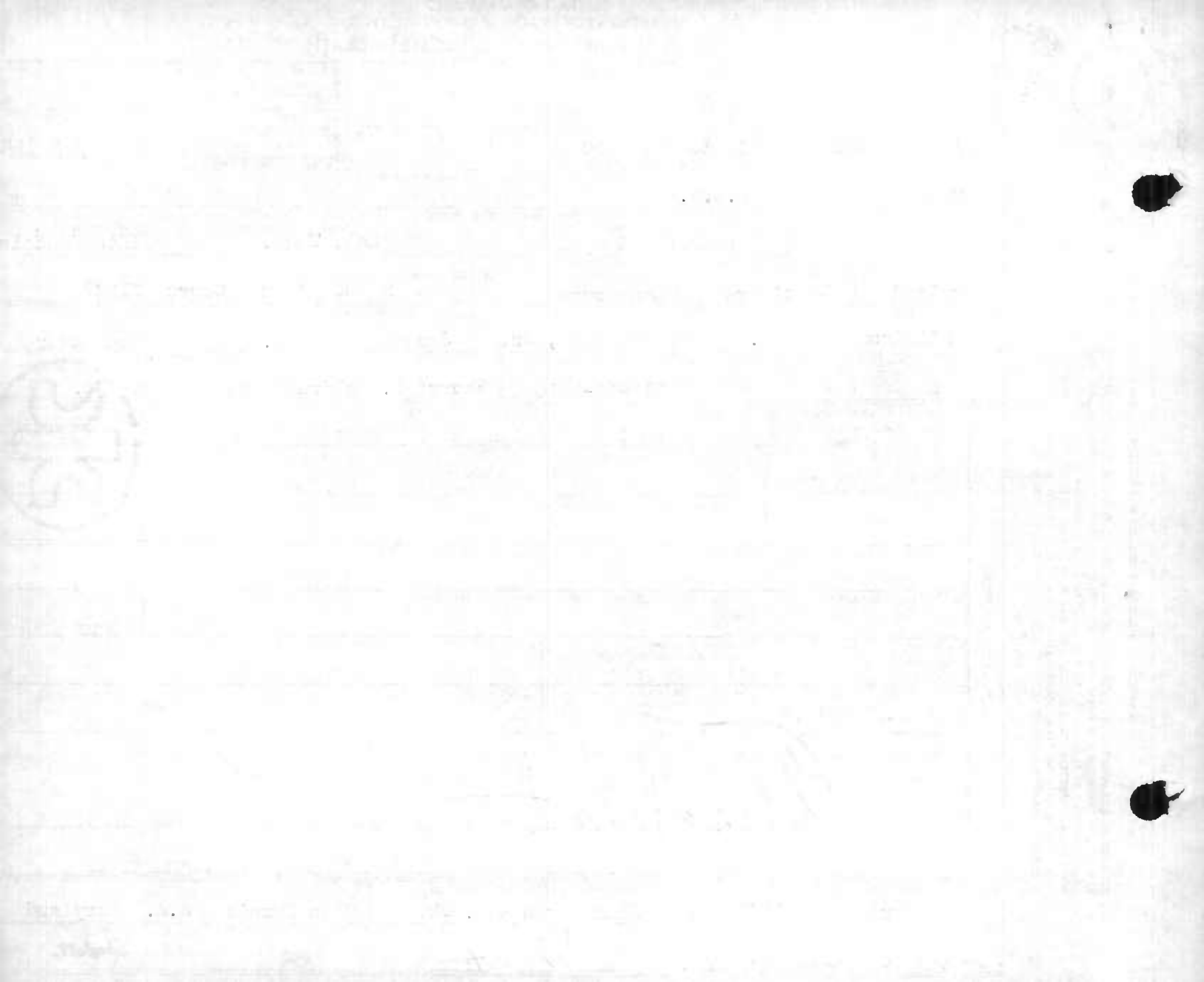
1. DECEASED NAME (TYPE OR PRINT)		FIRST WILLIAM		MIDDLE A		LAST CALDWELL		2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 12 13 19 84		2b. HOUR M 2:21A	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 10 54		6. AGE (IN YEARS) (LAST BIRTHDAY) 30 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 12 13 19 84		2d. HOUR 2:21A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab. Tech.		12b. KIND OF BUSINESS OR INDUSTRY Chesapeake Finish Metals			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lansdowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 900 Niagara Court 21227			
14. FATHER'S NAME FIRST MIDDLE LAST William A. Caldwell, Jr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane O. Neudecker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 217-66-3410		17. INFORMANT ADDRESS 21227 Sherri L. Caldwell 900 Niagara Ct.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chemical and mechanical injuries</u> 8839 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:40PM 12/12/19 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell into tank after explosion			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) factory				21f. LOCATION CHESAPEAKE FINISHED METALS CORP. 6754 Santa Barbara Ct, Elkridge, Howard Co, MD			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) Acting Chief				DATE SIGNED 12/13/84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				25a. DATE REC'D. BY REGISTRAR DEC 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, LEAD TO EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 WITHIN 72 HOURS TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



Item 13 per phone 12/11/84 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 4 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH EDWARD CALHOUN III			2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 28, 1984			2b. HOUR A 4:37 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 27 84		6. AGE (IN YEARS LAST BIRTHDAY) 1 DAY YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware				13b. CITY OR TOWN Dagsboro		13c. STREET ADDRESS / ZIP CODE Rt. 2, Box 74A 19939 99999	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH EDWARD CALHOUN, JR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MONA MURRAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS JOSEPH CALHOUN, JR.			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) CARDIOPULMONARY ARRESTAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

7 MIN

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) PULMONARY HYPOPLASIA

20 HRS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>27 NOV</u> 19 <u>84</u> to <u>28 NOV</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>28 NOV</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.							
22b. SIGNATURE <u>Barry J. Byrne</u>				DEGREE M.D.		22c. DATE SIGNED 11-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY J. BYRNE				22e. ADDRESS 600 N. WOLFE ST., BALTIMORE, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-1-84		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE'S CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CLARKSVILLE SUSSEX DELAWARE	
24. FUNERAL DIRECTOR NAME MELSON FUNERAL SERVICES FRANKFORD, DELAWARE 19945				25a. DATE RECEIVED BY DEC 8 1984			



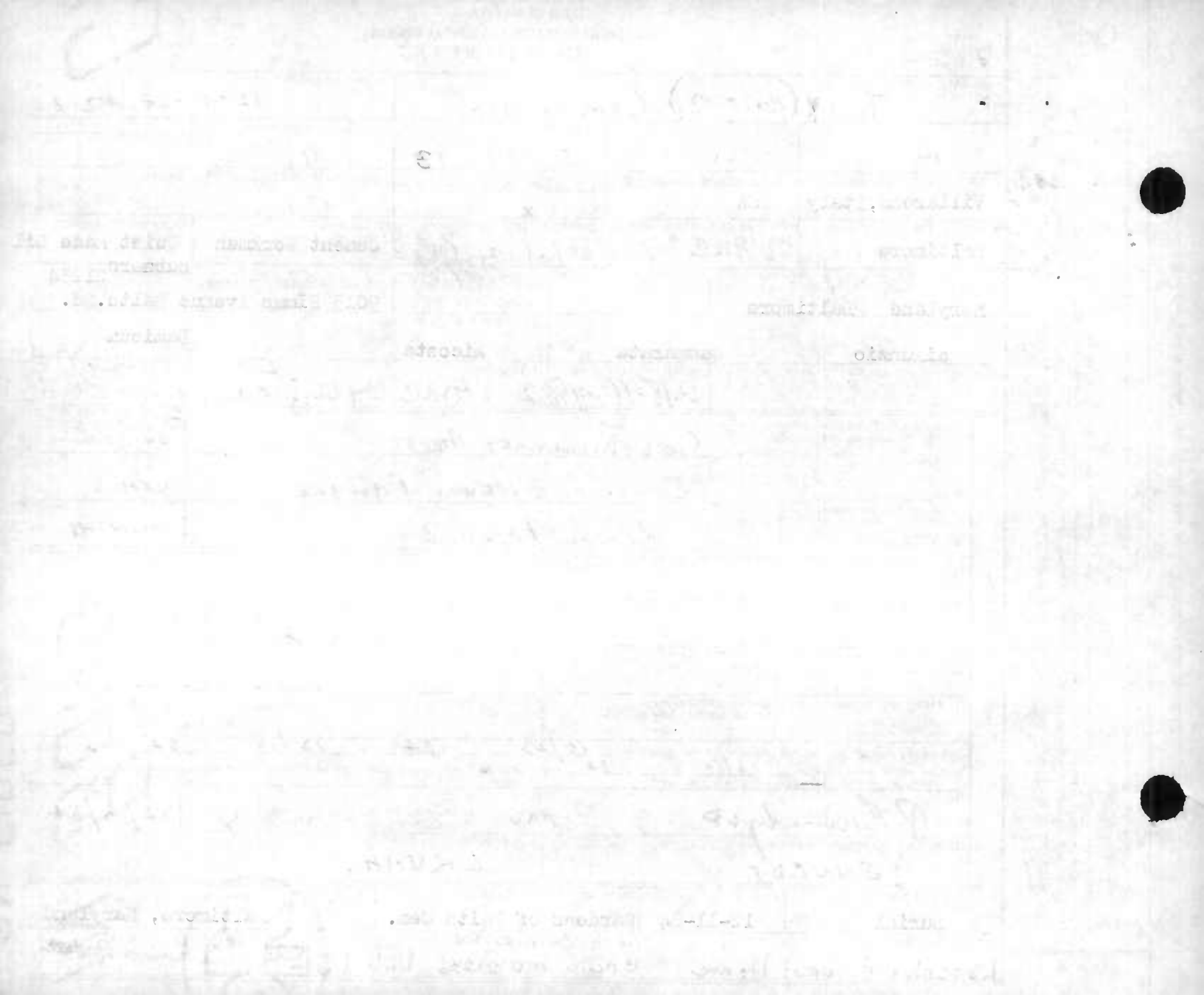
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be called to the scene of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 32549			
1. DECEASED NAME (TYPE OR PRINT) TONY (ANTHONY) CAMMARATA				2a. DATE OF DEATH MONTH DAY YEAR 12-10-84			
1. SEX m				2b. HOUR 4:20 A.M.			
3. RACE W		4. DATE OF BIRTH MONTH DAY YEAR 5 19 93		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN) Villarosa, Italy		9. CITIZEN OF WHAT COUNTRY? USA		10. BALTIMORE CITY OR COUNTY OF DEATH CITY, MD.			
11. CITY OR TOWN OF DEATH Baltimore		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION VANC 3900 Jack Raven Blvd		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cement Workman		13b. KIND OF BUSINESS OR INDUSTRY Quiet Made Oil	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE 14b. COUNTY 14c. CITY OR TOWN Maryland Baltimore				15. STREET ADDRESS / ZIP CODE 9013 Simms Avenue Balto.Md. 21234			
16. FATHER'S NAME FIRST MIDDLE LAST diNunzio Cammarata		17. MOTHER'S MAIDEN NAME FIRST MIDDLE Nicosta Damicia		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 218-10-4962 VANC 3900 Jack Raven Blvd			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) CONGESTIVE HEART FAILURE. (c) RENAL FAILURE				20. DEATH 20-30 min. YEARS MONTHS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		22d. LOCATION CITY OR TOWN COUNTY STATE	
22e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		22f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22g. LOCATION CITY OR TOWN COUNTY STATE		22h. I certify that (this hospital) attended the deceased from 10/23 1984 to 12/10 1984, that (we) lost saw the deceased alive on 12/10 1984, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (a) (we) (did) (view the body after death).	
22i. SIGNATURE J. Kennedy MD		22j. DEGREE MD		22k. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22l. DATE SIGNED 12/10/84	
22m. PHYSICIAN'S NAME (TYPE OR PRINT) KENNEDY		22n. ADDRESS LRVAH.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-11-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		25a. DATE REC'D. BY REGISTRAR DEC 13 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2550

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AARON J CANADA			2a. DATE OF DEATH MONTH DAY YEAR 12-30-84		2b. HOUR 6:40 A.M.
3 SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 1/05/27	6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH Balto. Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2008 W. Fayette St 21223
14. FATHER'S NAME FIRST MIDDLE LAST William Canada		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Winnie Carter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-24-8766	17. INFORMANT Tda Canada 2008 W. Fayette St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intractable congestive Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ischemic Heart Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> , 19 <u>84</u> , to <u>12/30</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death.)					
22b. SIGNATURE <u>Juan A. Beltran</u>		DEGREE M.D.		22c. DATE SIGNED 12/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN A. BELTRAN		22e. ADDRESS 1940 W. BALTIMORE ST, BALTO, MD			
23a. BURIAL, CREMATION, REMOVAL (TYPE)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	1-4-85	Garrison Forest VA		Owning Mills Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Wm. C. March 7/4. 1101 E. North Ave				JAN 3 1985	J. Davidson



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP _____

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 2 5 5 1

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM THOMAS CAPPARELLA			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 12-18-84			2b. HOUR M 1:39A		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 4 1937	6. AGE (IN YEARS) LAST BIRTHDAY 47 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 12-18-84		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE
13a. STATE MD.			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 152 CHAPELTOWN CIRCLE 21236		
14. FATHER'S NAME FIRST MIDDLE LAST PASCHAL CAPPARELLA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES HEBERLE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS same address VIVIAN CAPPARELLA (STEP-MOTHER)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) disease DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			TITLE (SPECIFY) Assistant			DATE SIGNED 12-18-84		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 12/20/84		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME ADDRESS SCHIMUNEK FUNERAL HOME, INC. 9705 Belair Rd. Balto. Md. 21236					25a. DATE REC'D. BY REGISTRAR DEC 21 1984		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 5 5 2					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hattie Belle Carter				2a. DATE OF DEATH MONTH DAY YEAR 12/16/84				2b. HOUR 10:00 PM	
3. SEX female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 7 21		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1919 Eutaw Place				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Dressmaking	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1919 Eutaw Place 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Spencer Spruill				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Athalia Harvis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217 12 3427		17. INFORMANT ADDRESS Cynthia Miller 1919 Eutaw Place					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arrest Box 20th Anniversary								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) COPD									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edhammed A. Morton			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jas. A. Morton & Sons			22e. ADDRESS 1701 Laurens St.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons						25a. DATE REC'D. BY REGISTRAR DEC 20 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP _____



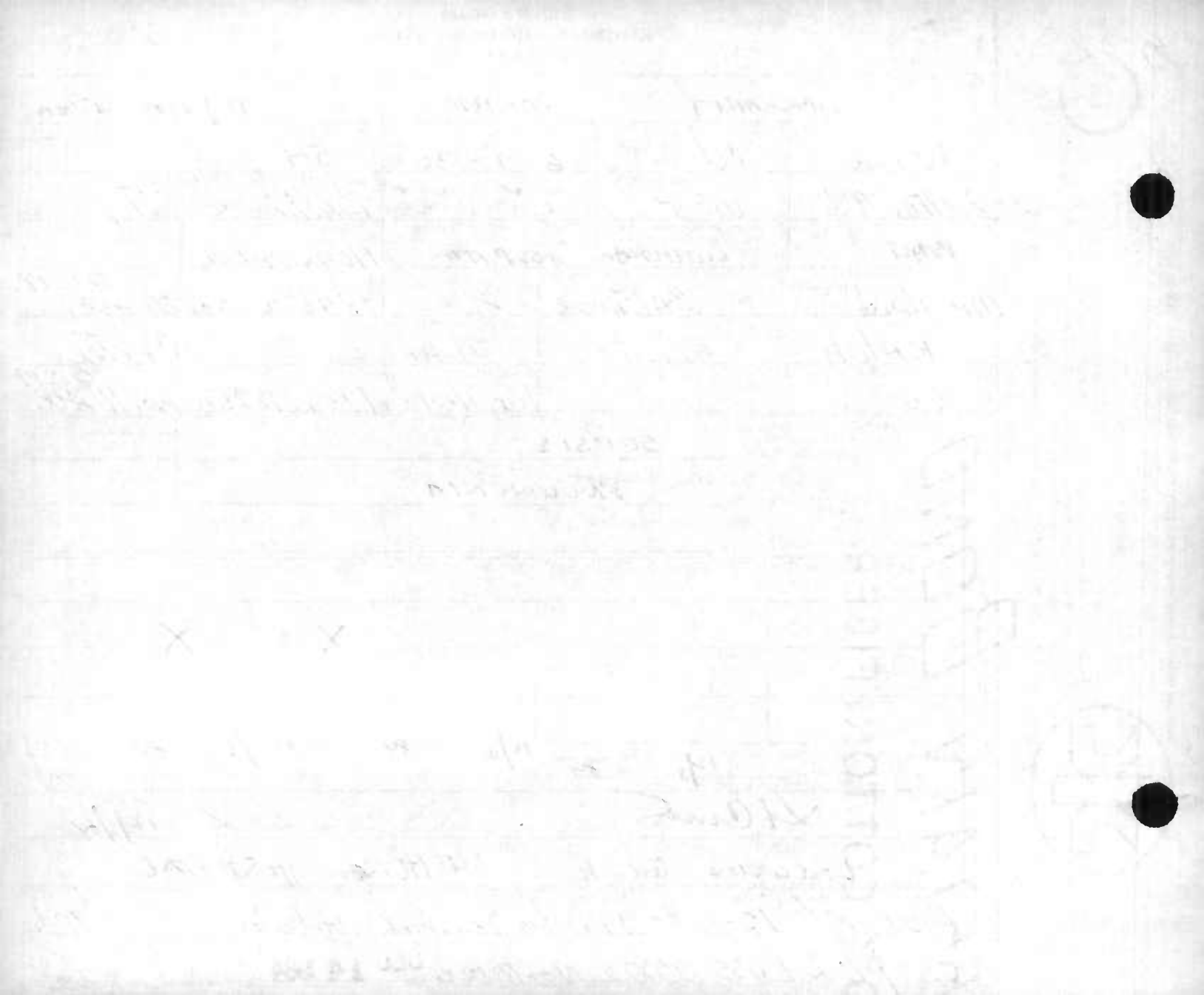
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 5 5 3			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET CARTER				2a. DATE OF DEATH MONTH DAY YEAR 12/5/84			
3. SEX Female		4. RACE Col		5. DATE OF BIRTH MONTH DAY YEAR 6-7-30		6. AGE (IN YEARS LAST BIRTHDAY) YRS 54	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt. Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. CITY OR TOWN Baltimore			
14. FATHER'S NAME FIRST MIDDLE LAST Ralph Higgins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Carter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO.			
17. INFORMANT ADDRESS Mr. Herbert Keys 1825 W. North Ave. 21217							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/1/84, 19 84, to 12/5/84, 19 84, that (I) (we) lost saw the deceased alive on 12/5/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE St. C. C.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leda Vira Quash				22e. ADDRESS LUTHERAN HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-11-84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.	
24. FUNERAL DIRECTOR NAME Joseph L. Russ				25a. DATE REC'D. BY REGISTRAR DEC 14 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson			



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BP

DHMH - 16 50M 4/83
(VRA 15, 4)

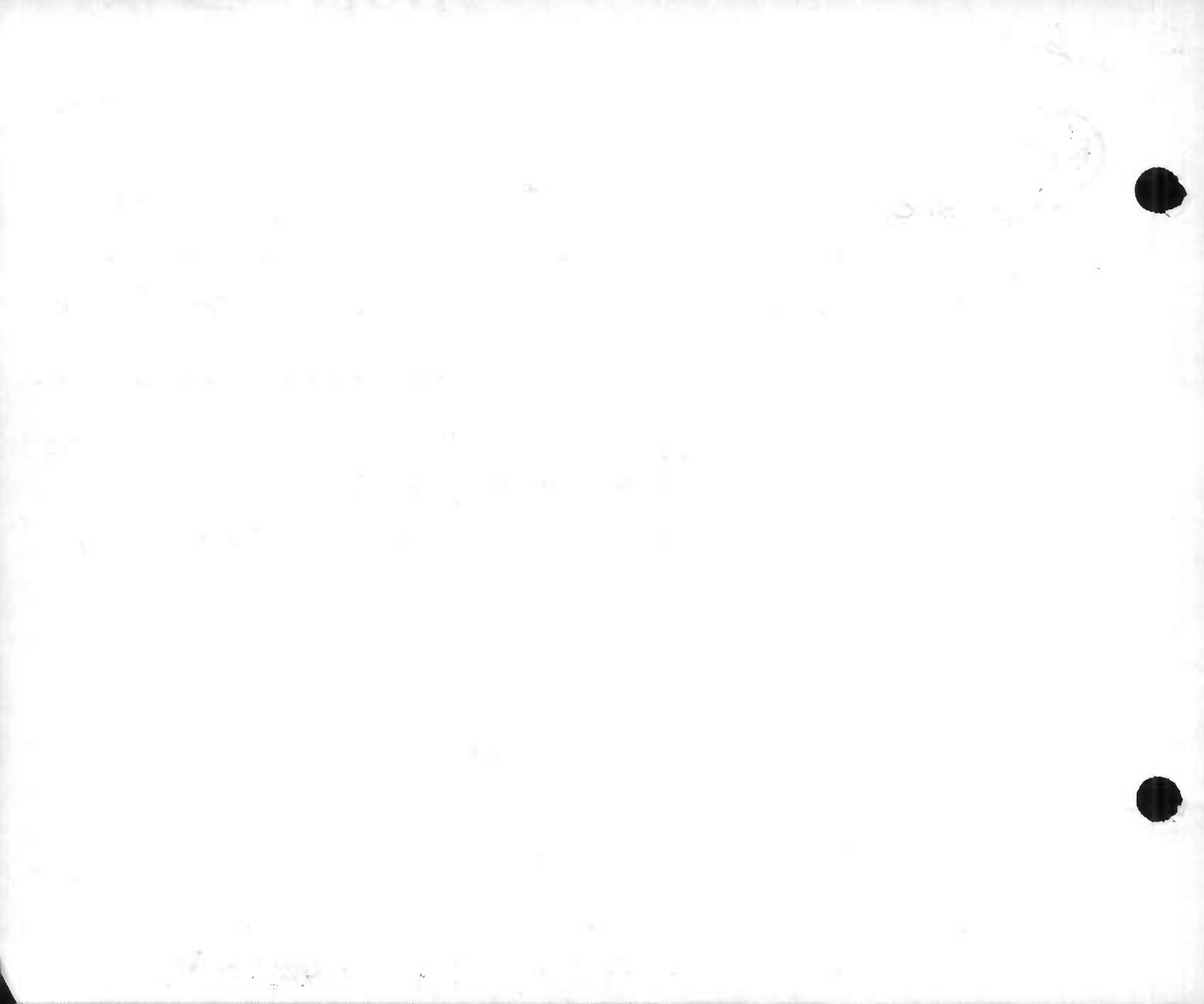
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 5 5 4

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roosevelt Carter			2a. DATE OF DEATH MONTH DAY YEAR 12 - 22 - 84		2b. HOUR MIN. 7 15 A.M.					
3 SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 06 20 36		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 48		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) S. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. General Hosp. Balto. Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly worker		12b. KIND OF BUSINESS OR INDUSTRY unknown		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Bc		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 929 Jopka Ave. Balto. Md 21225	
14. FATHER'S NAME FIRST MIDDLE LAST Dancy Carter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LiLlie Patterson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown			16b. SOCIAL SECURITY NO. 216 320176		17. INFORMANT Alma Carter ADDRESS 929 Jopka Ave. old chart 3001 S. Hanover ST., Balto Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (b) with metastatic disease and DUE TO, OR AS A CONSEQUENCE OF (c) complications including hypotension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DIAGNOSED METASTATIC TO LIVER + BRAIN SEPT. 1984		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11-19-84 19 84 , to 12-22 19 84 , that (I) (we) lost saw the deceased alive on Dec. 22 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Peter H Cooke MD						DEGREE MD		22c. DATE SIGNED 12-22-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter H Cooke MD						22e. ADDRESS 3001 S. Hanover ST., Balto., Md 21230				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/26/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 26 1984		
						25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall				



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 32555	
1. FOR STATE REGISTRAR			1. DECEASED NAME		2a. DATE OF DEATH	
			FIRST MIDDLE LAST (Kasprzak) ANNA B CASPER		MONTH DAY YEAR 12/28/84	
3. SEX			4. RACE		5. DATE OF BIRTH	
Female			White		MONTH DAY YEAR Sept. 8 1896	
7a. BIRTHPLACE			7b. CITIZEN OF WHAT COUNTRY?		6. AGE	
Pa.			USA		(IN YEARS LAST BIRTHDAY) 88	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		9. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore			Mercy Hospital		Baltimore City MD.	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	
Md.			Balto.		13d. INSIDE CITY LIMITS?	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS	
John			Slivinski		811 N. Kenwood Ave. 21212	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO			215-10-9923		Lorraine Jacob 1529 Northbourne Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:					3 months	
IMMEDIATE CAUSE (a) RENAL FAILURE AND						
DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
DUE TO, OR AS A CONSEQUENCE OF PROBABLE LEUKEMIA.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
		HOUR A.M. MONTH DAY YEAR P.M. 19				
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		
WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 84 to DEC 28 84, that (I) (we) last saw the deceased alive on 12/28/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
Nelson C. Sun						12/28/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
Nelson C. Sun		301 ST. PAUL PLACE BALTIMORE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		12-31-84		Holy Rosary Cemetery		Balto... MD
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John M. Weber & Sons Inc. 401 S. Chester St.		JAN 2 1985		Julia Davidson-Randall		

20% CO₂ in air
$$\frac{1}{2} \frac{d}{dt} \left(\frac{1}{2} \frac{d}{dt} \right) = \frac{1}{2} \frac{d}{dt} \left(\frac{1}{2} \frac{d}{dt} \right)$$

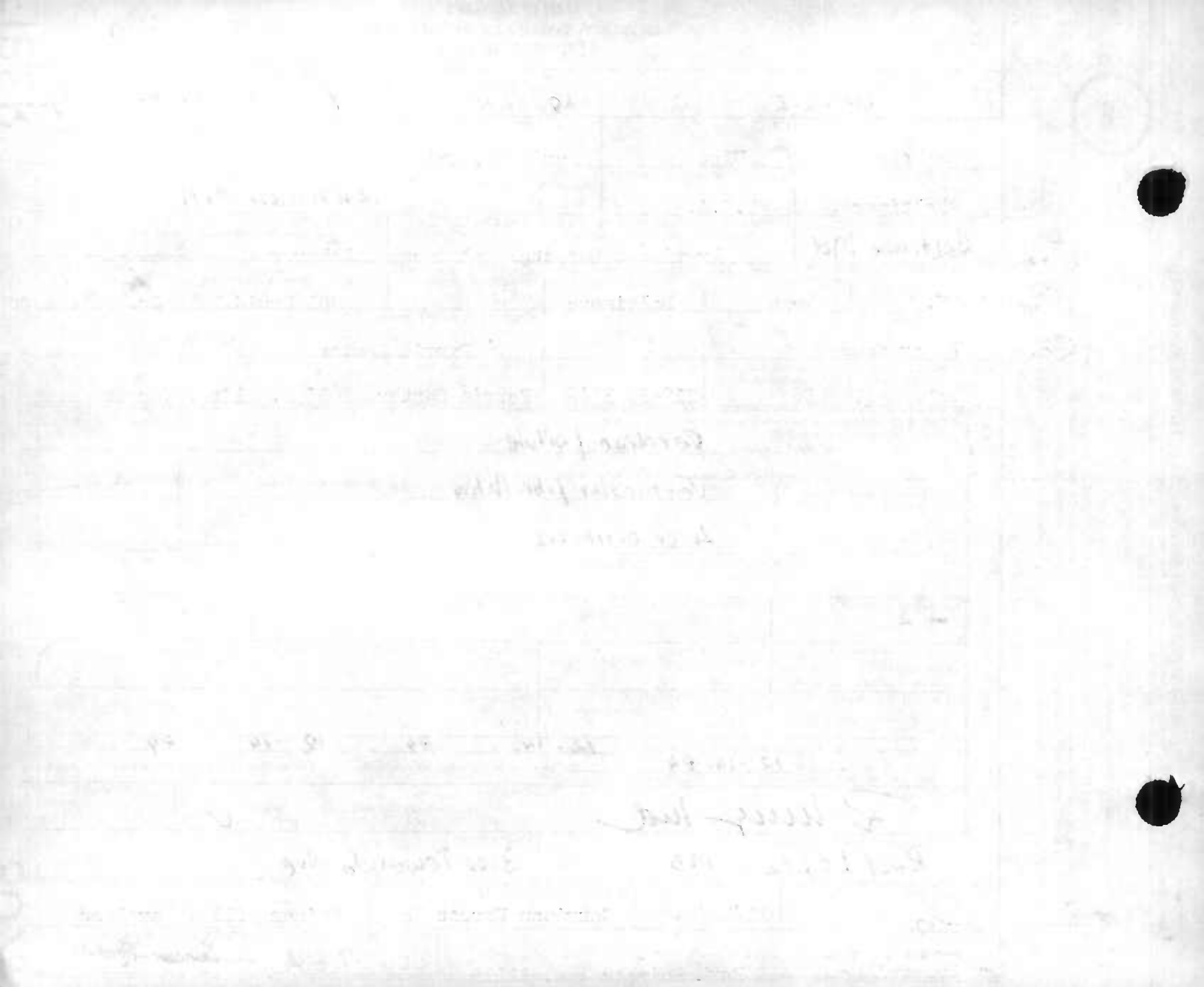
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 2 5 5 6																			
1. FOR STATE REGISTRAR					REG. NO.																								
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR													
WILLIE R. CAUSER										12 14 84				7 ¹⁵ PM															
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		8. UNDER 24 HRS.																
Male			Black		April 10, 1948			36 YRS.			MONTHS DAYS		HOURS MIN.																
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																					
Baltimore, Md			U.S.A.					Baltimore City MD.																					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore Md			Provident Hospital Baltimore										Laborer -----0-----			-----0-----													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. STATE					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS / ZIP CODE									
					Md.					None					Baltimore					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					901 Druid Lake Dr. Baltimore 21217				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
Edgar Causer					Parrie Carter																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS																			
Yes RA11-570-156					219-50-1345					Parrie Carter, 2026 E. 31st. Street																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
IMMEDIATE CAUSE (a) <u>Cardiac failure</u>																													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular fibrillation</u>																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Liver cirrhosis</u>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																			
					HOUR A.M. MONTH DAY YEAR P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION																			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-14</u> , 19 <u>84</u> , to <u>12-14</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-14-84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE					22c. DATE SIGNED														
<u>R. Lopez</u>										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS																			
Raul Lopez MD										3100 Towanda Ave																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION														
Burial					12/20/84					Garrison Forest Va					CITY OR TOWN COUNTY STATE														
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE																			
										DEC 17 1984 Julia Davidson-Randall																			
Law Funeral Home 4611 Park Heights Ave. 21215																													



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210-92-75

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. The funeral director must be notified immediately. If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notified to the State Dept. of Health and Mental Hygiene.

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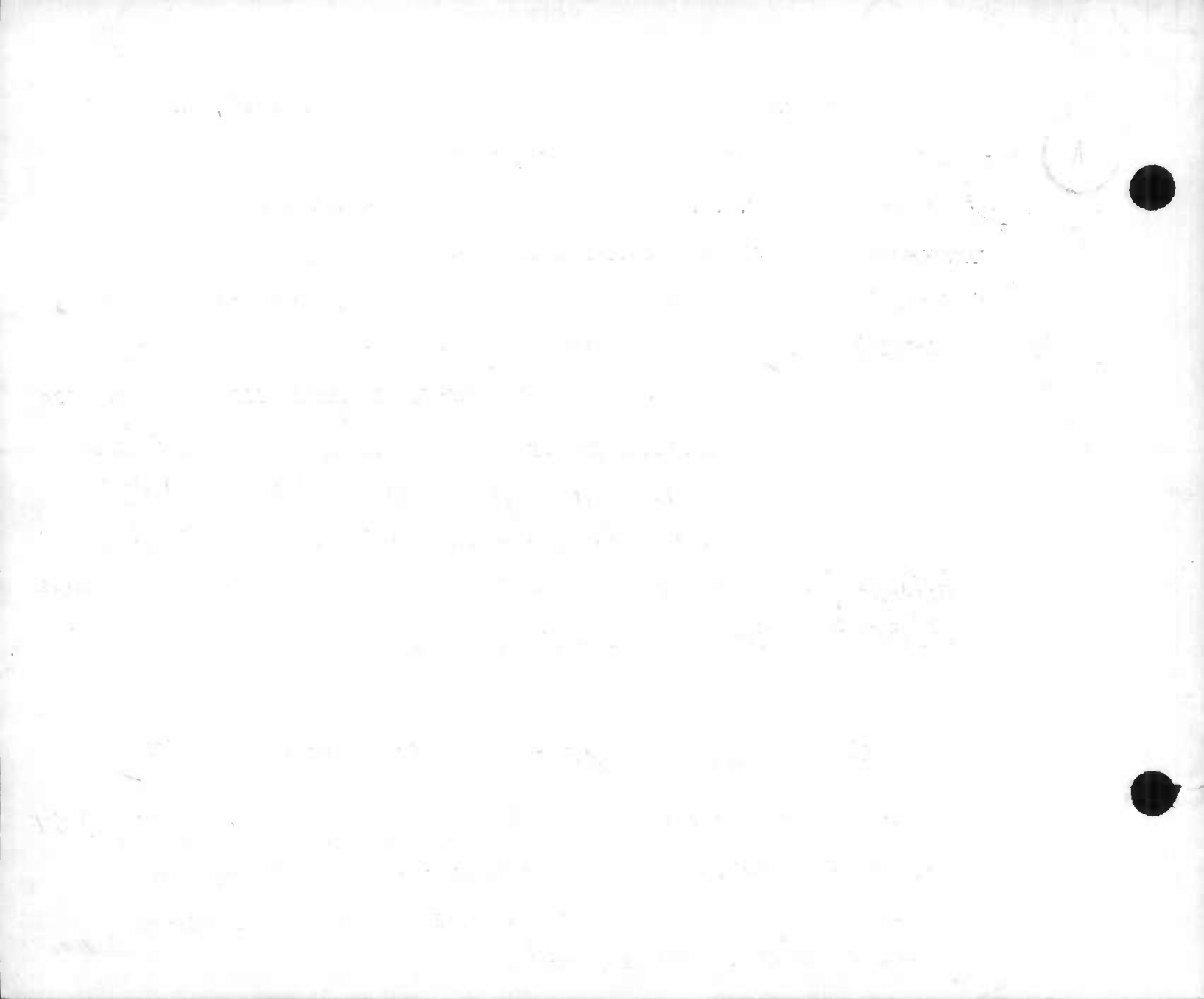
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 5 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NICOLE K CERCHIO			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 30, 1984		2b. HOUR P 5:46 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov 13, 1973		6. AGE (IN YEARS LAST BIRTHDAY) 11 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware		13b. COUNTY Wilmington	13c. CITY OR TOWN Wilmington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4 Courtney Rd 19807
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas L Cerchio III		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marge Gamble			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mr Nicholas L Cerchio III Same As 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Liver failure, Kidney failure, pancreatitis DUE TO, OR AS A CONSEQUENCE OF (c) Aplastic Anemia, S/P Bone Marrow Transplant					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 12 days 17 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Aplastic Anemia, S/P Bone marrow transplant, apparently mild graft vs host disease					
19a. DATE OF OPERATION 12/13/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bone Marrow Transplant for Aplastic Anemia		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 12/21 , 19 84 , to 12/30 , 19 84 that (b) (we) lost saw the deceased alive on 12/30 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rose Christopherson		DEGREE MD		22c. DATE SIGNED 12/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rose Christopherson		22e. ADDRESS Anes. & critical care medicine Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/85		23c. NAME OF CEMETERY OR CREMATORY St James Episcopal	
23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Delaware		23e. DATE RECEIVED BY REGISTRAR JAN 2 1985			
24. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland		25a. DATE RECEIVED BY REGISTRAR JAN 2 1985			



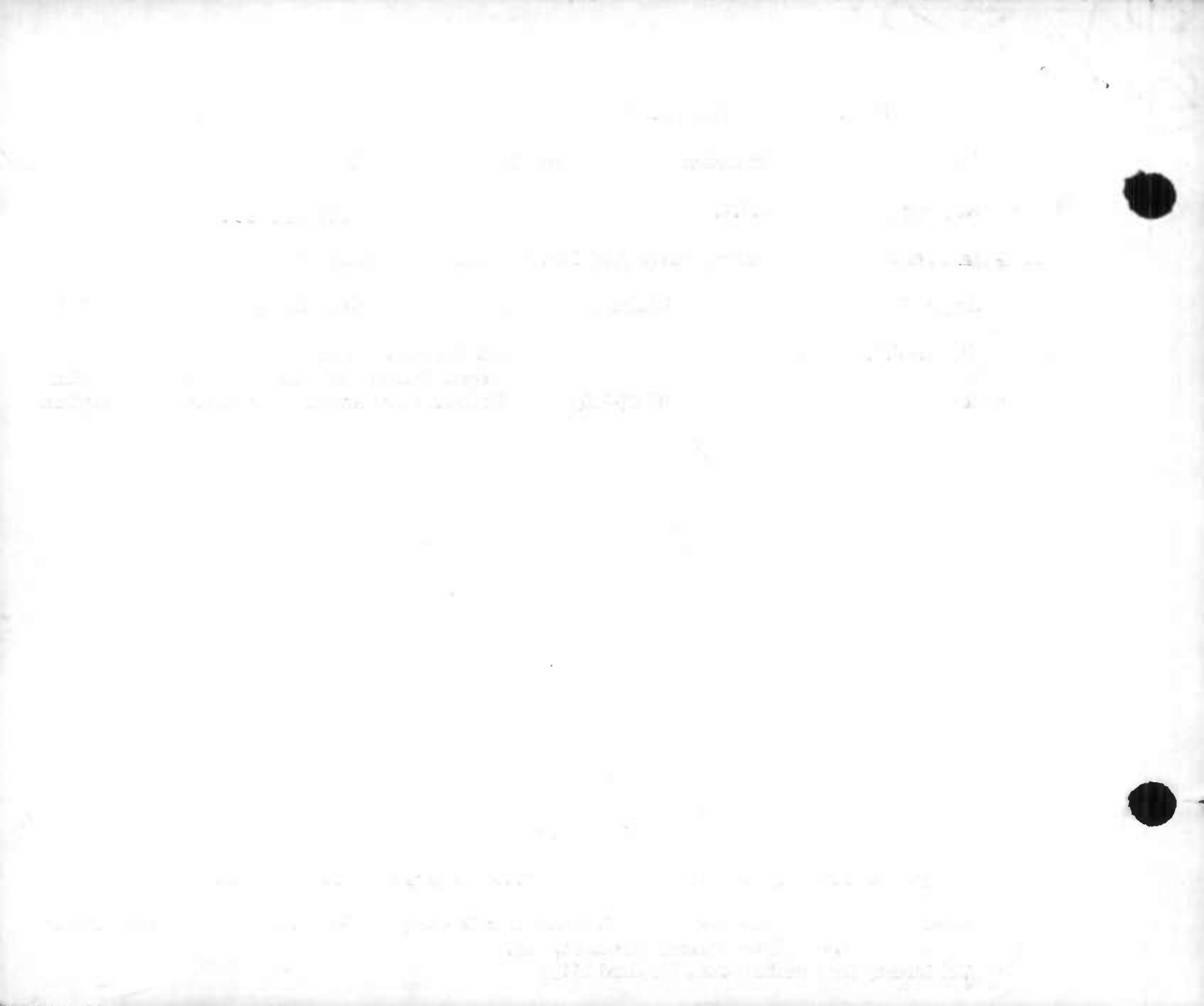
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 2 5 5 8			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mrs. Hilda Chambers				2a. DATE OF DEATH MONTH DAY YEAR December 28 1984			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 26 1889		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 95 YRS.	
7a. BIRTHPLACE (COUNTRY) STATE OR FOREIGN Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) General German Aged People's Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William J.S. Millar				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Valentine Millar			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-07-7263		17. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) General German Aged People's Home		17b. ADDRESS 22 South Athol Avenue Baltimore Maryland 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) Blood's disorder							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 1983 to 28 Dec 1984 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE William J. Bryson				DEGREE M.D.		22c. DATE SIGNED 31 Dec 84	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William J. Bryson				22c. ADDRESS 6772 Westview Mall 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 31 1984 John Davidson-Randall			



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 5 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John C. Chapman SR			2a. DATE OF DEATH MONTH DAY YEAR 12-6-84		2b. HOUR M
3 SEX MALE	4 RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 5 24 17		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2918 THE AIAMEDA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY		
13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 2918 The AIAMEDA			13f. CITY OR TOWN 21218		
14. FATHER'S NAME FIRST MIDDLE LAST John Chapman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Keys		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Beverly Chapman 2918 THE AIAMEDA	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) stroke . CVA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

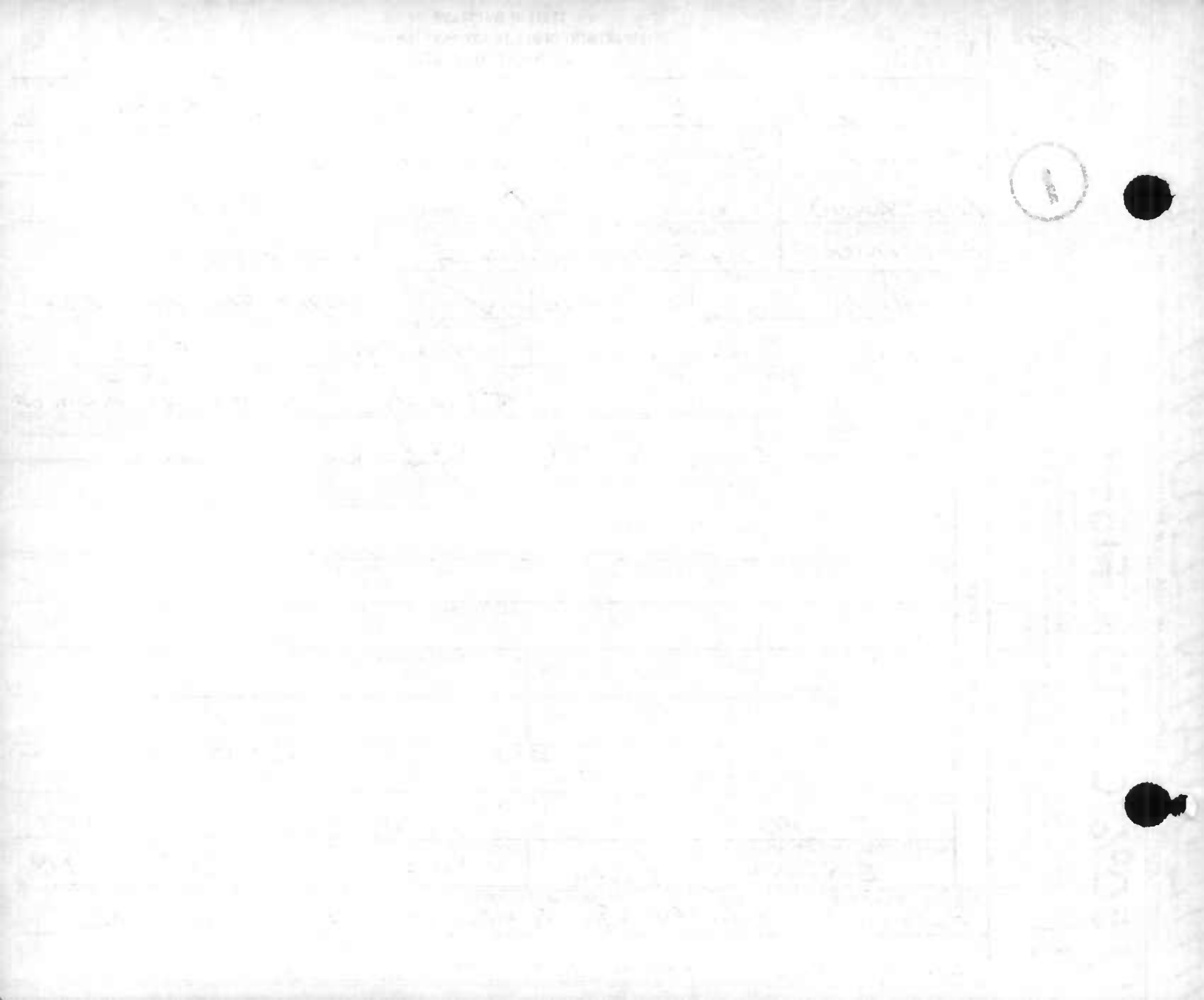
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 1984 to 12-6-84 , 19 84 , that (I) (we) last saw the deceased alive on 12-5 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE I. Ch...		DEGREE		22c. DATE SIGNED 12-7-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C HEIKH ISSAM		22e. ADDRESS 201 E Univ PKWY Balto		22f. CITY OR TOWN BALTIMORE	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/10/84	23c. NAME OF CEMETERY OR CREMATORY KING MEM. PK.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.
24. FUNERAL DIRECTOR NAME E.L. Phillips		25a. DATE REC'D. BY REGISTRAR DEC 10 1984	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 4		REG. NO. 2 5 6 0					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
DOROTHY		M. CHEATMAN		12-24-84		5 35		PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
F		B		8 30 1902		82 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
VA.		U.S.A.				Balto. City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Francis Scott Key		Housewife		Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		Balto.		Turners St		12-22-22			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Samuel Wheeler		Mariah North		none		Doris Bagley 110 East Avenue			
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		20. SOCIAL SECURITY NO.		21. INFORMANT ADDRESS			
no		no		none		Doris Bagley 110 East Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cerebrovascular Disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Andrew Goldberg MD						12/25/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
ANDREW GOLDBERG									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/29/84		Mt. Calvary		Balto., Md.			
24. FUNERAL DIRECTOR NAME		24. FUNERAL DIRECTOR ADDRESS		25. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE)					
Jas. A. Morton & Sons		1701 Laurens		DEC 28 1984					

MEDICAL CERTIFICATION

1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 6 1

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth G. Cherry			2a. DATE OF DEATH MONTH DAY YEAR 12 10 84			2b. HOUR 8 05 PM	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 5 02		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUBURBANITY, GIVE STREET ADDRESS) Provident Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Dent				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-30-3362		17. INFORMANT BEN Gamin F. Cupid			
				ADDRESS Los Angeles, Calif, Park Ave. 505 S. Lafayette			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) Hypertensive atherosclerotic heart disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Small intestine							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/10/84 to 12/10/84 , that (I) (we) last saw the deceased on or above, (I) (we) did not view the body after death.							
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. SINGH				22e. ADDRESS Provident Hospital			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/17/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Maryland	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 14 1984	
						25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove entire pages 1 and 2 and file in the appropriate file after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				3 2 5 6 2 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Rose C Cherry				2a. DATE OF DEATH MONTH DAY YEAR 12 21 84 2b. HOUR 1205 M			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 15 05		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Freeland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen Gattus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kapasak		13e. STREET ADDRESS / ZIP CODE 21609 Middletown Rd. 21053			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-20-7101		17. INFORMANT ADDRESS Mrs. Margaret Bouchillon 21603 Middletown Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASCUD years (c) CHF years							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atrial Fibrillation							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/18 , 19 84 , to 12/21 , 19 84 , that (I) (we) lost saw the deceased alive on 12/21/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard R. Jones				DEGREE SINAI		22c. DATE SIGNED 12/21/84	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD R. JONES				23b. ADDRESS SINAI			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-24-84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Balto, Maryland	
24. FUNERAL DIRECTOR Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR DEC 24 1984			
25b. REGISTRAR'S SIGNATURE [Signature]							

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 2 5 6 3

1. DECEASED NAME (TYPE OR PRINT) Mr. Victor Chiccino			2a. DATE OF DEATH MONTH DAY YEAR December 25 1984			2b. HOUR M				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 10 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven Veterans Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Refin. Floor		
13a. STATE Maryland			13b. COUNTY Balto. City		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1233 Church Street 21225	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Chiccino				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mrs. Ruth Chiccino						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. ADDRESS 1233 Church Street		17b. ADDRESS Glen Burnie		17c. ADDRESS Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) S/P Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (c) S/P (r) CVA- COMA									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 20 19 84 to DECEMBER 25 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 25 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joyce B. Harp MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOYCE B. HARP MD						22e. ADDRESS VAMC, Baltimore, Maryland 21218				
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 12-28-84		23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Cemetery		23d. LOCATION Garrison Fst Baltimore Maryland			
24. BURIAL PLACE (NAME) Loring Myers Funeral Directors, Inc.						25a. DATE REC'D. BY REGISTRAR DEC 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 6 4

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Richard W. Childress			2a. DATE OF DEATH MONTH DAY YEAR 12 13 84		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 29 39		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 510 West 33rd Street 21211		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Photographer	12b. KIND OF BUSINESS OR INDUSTRY Sun Papers	
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY --	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 510 West 33rd St. 21211	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Kerner Childress			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marian (unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1959-61		17. INFORMANT ADDRESS Mr. Doug Kelso 1415 Johns Street 21217	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Colon Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY AND TIME IN PART 1 OR PART 2)		
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AG HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>84</u> to 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>12-13-84</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.					
22b. SIGNATURE <u>Richard L Diamond</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-13-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD L DIAMOND		22e. ADDRESS 3547 Chestnut Ave 21211			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/15/84	23c. NAME OF CEMETERY OR CREMATORY Bethel Presbyterian		23d. LOCATION CITY OR TOWN COUNTY STATE Madonna Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211		25a. DATE REC'D BY REGISTRAR DEC 18 1984			
		25b. REGISTRAR'S SIGNATURE <u>J. A. Seitz</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be conducted at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 2 5 6 5

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FUNG KWAI CHIN-LEE			2a. DATE OF DEATH MONTH DAY YEAR 11 27 84		2b. HOUR 10:40 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 21, 1892	6. AGE (IN YEARS LAST BIRTHDAY) 92	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China	7b. CITIZEN OF WHAT COUNTRY? China	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. STREET ADDRESS / ZIP CODE 3620 Greenmount Ave. 21218	
14. FATHER'S NAME FIRST MIDDLE LAST Lee Sen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lui Senz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-34-2943B	17. INFORMANT ADDRESS Chuang Mon Chan Same			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resp Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Urinary Tract Infection DUE TO, OR AS A CONSEQUENCE OF (c) Advanced Age					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10:10 PM - 10:40 PM one week
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d) DEMENTIA					
19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> N/A	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK N/A	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) N/A	21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22a. I certify that (I) (this hospital) attended the deceased from 11/27 , 19 84 , to 11/27 , 19 84 , that (I) (we) last saw the deceased alive on 11/27 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John Thomas Evelius		DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/27/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN THOMAS EVELIUS M.D.		22e. ADDRESS UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 5, 1984	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park	23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. Co., Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Stewart & Mowen Co, Baltimore, Md. 21201		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 12 1984			

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